92 09001

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGARET Biebl BIEBL (Margaret Biebl)			2. DATE OF DEATH MONTH 3 DAY 27 YEAR 92	3. TIME OF DEATH 1340 M
4. SOCIAL SECURITY NUMBER: 212-01-9488	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 3, 1902	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): THE UNION MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore ~~City~~ Rosedale		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1619 Weyburn Rd.		10f. ZIP CODE: 21237		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yr's; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): John C. Wagner			18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Yeager	
19a. INFORMANT'S NAME (Type/Print): Mrs. Patricia Biebl		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Hilltop DATE: 3/28/92		20c. LOCATION — City or Town, State: Towson, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock, Jr. ▶ Paul L. Hartsock Jr.		22. NAME AND ADDRESS OF FACILITY: Baltimore, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Urinary tract infection
DUE TO (OR AS A CONSEQUENCE OF):
c. dementia
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe rheumatoid arthritis
gangrenous feet

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

26e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D37573	▶ 3/27/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jeff Tibell MD 7220 Park Heights Ave. Baltmore MD 21208

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 30 1992	Lina Davidson-Randall

DHMH-16 Rev 1/89

92 09002

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NORA MAY Browne
2. DATE OF DEATH — MONTH: 03 DAY: 27 YEAR: 92
3. TIME OF DEATH: 6:15AM M
4. SOCIAL SECURITY NUMBER: 218-12-4049
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): ~~80~~ 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 03-26-13
8. BIRTHPLACE (State or Foreign Country): Balto, Md.
9a. FACILITY NAME (If not institution, give street and number): Eastpoint Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Dundalk
9c. COUNTY OF DEATH: Baltimore Co.

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: BAltimore
10c. CITY, TOWN OR LOCATION: Middle River
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3701 D White Pine Road
10f. ZIP CODE: 21220
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY: Stewarts Dept. Store
17. FATHER'S NAME (First, Middle, Last): William Nine
18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude Scheafer
19a. INFORMANT'S NAME (Type/Print): Wayne Browne
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3701 D WhitePine Road BAltimore MAryland 21220
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Cemetery — DATE: 3/30/92
20c. LOCATION — City or Town, State: BAltimore Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home
22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MAceAve. 21221

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardio-Pulmonary arrest	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	AS(VI)	YEARS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Rt. upper lobe f/sputum - 1per trunPos. for AFB X1 Culture Resulting.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] ASS-MEDICAL DIRECTOR
29c. LICENSE NUMBER: D-14618
29d. DATE SIGNED (Month, Day, Year): 3/27/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BIENVENIDO R. MATOS 21 CRANBROOK Rd. COCKEYSVILLE Md. 21030
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: [illegible]

DHMH-16 Rev 1/89

92 09003

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jessie Virginia Brown
2. DATE OF DEATH (Month, Day, Year): March 30, 1992
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 218-22-7925
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): March 25, 1927
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 316 Savannah Road
9b. CITY, TOWN OR LOCATION OF DEATH: Essex
9c. COUNTY OF DEATH: BAltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: BAltimore
10c. CITY, TOWN OR LOCATION: Essex
10d. INSIDE CITY LIMITS? 1 ☐ YES ☒ NO
10e. STREET AND NUMBER: 316 Savannah Road
10f. ZIP CODE: 21221
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: ☒ 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Meat Packing
16b. KIND OF BUSINESS/INDUSTRY: Esskay
17. FATHER'S NAME (First, Middle, Last): Francis H. Brown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma Brumwell
19a. INFORMANT'S NAME (Type/Print): Pat Travers
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 316 Savannah Road BAltimore MAryland 21221
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith | DATE: 4/2/92
20c. LOCATION — City or Town, State: Rossville Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home
22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MAceAve. 21221

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	1 day
DUE TO (OR AS A CONSEQUENCE OF): b.	Myocardial Infarction	3 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Coronary Atherosclerosis	8 yrs
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D09516
29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Jay Platt 2809 Boston Street Baltimore MAryland
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Lidia Davidson-Randall

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR Joanne Blessing

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09004
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joanne Blessing
2. DATE OF DEATH: MONTH 3 DAY 22 YEAR 92
3. TIME OF DEATH: 10:35 PM M
4. SOCIAL SECURITY NUMBER: 213-52-5281
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 43 YRS. IF UNDER 1 YEAR — MONTHS DAYS; IF UNDER 24 HRS. — HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 03-31-48
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): DHMC Deaton
9b. CITY, TOWN OR LOCATION OF DEATH: Balto, Baltimore
9c. COUNTY OF DEATH: ---------N/A---------

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Balto.
10c. CITY, TOWN OR LOCATION: Balto.
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1713 White Oak Road
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary
16b. KIND OF BUSINESS/INDUSTRY: Maryland Casualty Ins.
17. FATHER'S NAME (First, Middle, Last): William E. Blessing, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine M. Bechelli
19a. INFORMANT'S NAME (Type/Print): Josephine Blessing
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1713 White Oak Road Baltimore, MD 21234
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery — DATE 3/25
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Cori L. Clough
22. NAME AND ADDRESS OF FACILITY: Johnson Funeral Home Baltimore, MD 8521 Loch Raven Blvd. 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Amyotrophic Lateral Sclerosis	Yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure
Respiratory Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D14622
29d. DATE SIGNED (Month, Day, Year): ▶ 3/23/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H. L. McKee 611 S. Charles St Balto Md 21230
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09005
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): Grace E. Cheek				2. DATE OF DEATH (Month, Day, Year): March 30 1992	3. TIME OF DEATH: 12:30 P M
4. SOCIAL SECURITY NUMBER: 215-22-9958	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 30,1912	8. BIRTHPLACE (State or Foreign Country): Alabama
9a. FACILITY NAME (If not institution, give street and number): 1025 Hewitt Way			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATN: - - - -

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: - - - -	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1025 Hewitt Way		10f. ZIP CODE: 21205	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): H. T. Black		18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Black	
19a. INFORMANT'S NAME (Type/Print): Carl W. Cheek		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 807 Woodrow Ave., Baltimore, Md. 21221	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, cremetory or other place): Holly Hill Memorial Gardens	DATE	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home, Inc. 3331 Brehms Lane Baltimore, Md. 21213	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATN (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] LARRY L. TILLEY, M.D. 1012 North Point Rd. Baltimore, MD 21224		29c. LICENSE NUMBER: D11054	29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)			
31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: [signature]		

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RICHARD ANTHONY COOPER
2. DATE OF DEATH (Month, Day, Year): 03 28 1992
3. TIME OF DEATH: 3:15 p M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 22 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-25-69
8. BIRTHPLACE (State or Foreign Country): Phila. Pa.

9a. FACILITY NAME (If not institution, give street and number): HARFORD MEMORIAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: HAVRE DE GRACE
9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: Pa.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Phila.
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3029 W. Dakota St.
10f. ZIP CODE: 19132
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Welder
16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): Anthony Brooks
18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Brooks

19a. INFORMANT'S NAME (Type/Print): Bertha Brooks
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3029 W. Dakota St.

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Crematory, or other place): Mt. Peace — DATE:
20c. LOCATION — City or Town, State: Phila., Pa.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: William C. Brown Community FH, 1206 W. North Ave. Balto., Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	gunshot wound of thorax — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	DUE TO (OR AS A CONSEQUENCE OF):	
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 03/28/1992
28b. TIME OF INJURY: 1:45 M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: SUBJECT SHOT
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): PUBLIC STREET
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): FRONT OF 230 BLOOMSBURG AVENUE HAVRE DE GRACE, MARYLAND

29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): 03/29/1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] 111 PENN STREET BALTIMORE, MARYLAND 21201

31. DATE FILED (Mo., Day, Year): MAR 31 1992
32. [signature]

DHMH-16 Rev 1/89

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92 09007

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): IDA B. COVINGTON
2. DATE OF DEATH (Month, Day, Year): MARCH 28, 1992
3. TIME OF DEATH: 5:55 P M
4. SOCIAL SECURITY NUMBER: 213-10-3941
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): June 10, 1902
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Maryland Masonic Homes
9b. CITY, TOWN OR LOCATION OF DEATH: Cockeysville
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Cockeysville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 300 International Circle
10f. ZIP CODE: 21030
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Harry Bregal Krebs
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Keener
19a. INFORMANT'S NAME (Type/Print): Maryland Masonic Homes
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 International Circle Cockeysville, Md. 21030
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery | DATE: 4/2/92
20c. LOCATION — City or Town, State: Pikesville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F. Burnside Jr. / James F. Burnside, Jr.
22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Aspiration Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Dementia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D 25488
29d. DATE SIGNED (Month, Day, Year): March 31, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul M. Rivas, M.D. 300 International Circle Cockeysville, Md. 21030
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09008
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MABEL C COWMAN			2. DATE OF DEATH (Month, Day, Year): 3 30 '92	3. TIME OF DEATH: 1302 PM
4. SOCIAL SECURITY NUMBER: 214-22-5525	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 2-22-16	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): THE UNION MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3501 St. Paul Street		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Baltimore City
17. FATHER'S NAME (First, Middle, Last): UNK.		18. MOTHER'S NAME (First, Middle, Maiden Surname): UNK.	
19a. INFORMANT'S NAME (Type/Print): Joan Goldthorp		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 310 Arch St. Perkasie Pennsylvania 18944	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery	DATE: 4/1	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis Stephen Xenakis M00640		22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. bradycardia	5'
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CHF	5 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CML	several mo
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. metabolic acidosis	2 wks

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Christopher B Gordon MD

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Union Memorial Hospital 201 E University Pkwy Balt MD 21218

31. DATE FILED (Month, Day, Year): MAR 31 1992

32. REGISTRAR'S SIGNATURE: Julie Gordon-Reeves

DHMH-16 Rev 1/89

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92 09009

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harry M. Croney	HARRY M CRONEY	2. DATE OF DEATH (Month, Day, Year): 03 24 92	3. TIME OF DEATH: 3:05 P M	
4. SOCIAL SECURITY NUMBER: 218-46-7983	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10/09/10
8. BIRTHPLACE (State or Foreign Country): Maryland				
9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: na		

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: na	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1501 N. Dukeland	10f. ZIP CODE: 21207	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)

16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last)

18. MOTHER'S NAME (First, Middle, Maiden Surname)

19a. INFORMANT'S NAME (Type/Print)

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) in state

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) / DATE

20c. LOCATION — City or Town, State

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir

22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD 655 W, Baltimore St. Balto., MD 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reepiratory arrest, shock, or haart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Aspiration pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Respiratory failure

DUE TO (OR AS A CONSEQUENCE OF):

c. Septic Shock

DUE TO (OR AS A CONSEQUENCE OF):

d. Dehydration

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardio-Pulmonary arrest

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) / 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Attending Physician / 29c. LICENSE NUMBER: D30115 / 29d. DATE SIGNED (Month, Day, Year): 3/24/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): T. Ohikpehai, MD 2600 Liberty Hgts Ave Balt., MD 21215

31. DATE FILED (Month, Day, Year): MAR 30 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson Registrar

DHMH-16 Rev 1/89

92 09010

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Andrew Cook Jr. (William Cook)
2. DATE OF DEATH (Month, Day, Year): MARCH 30 1992
3. TIME OF DEATH: 6:13 a. M
4. SOCIAL SECURITY NUMBER: 218-40-4508
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 48 YRS.
   IF UNDER 1 YEAR: MONTHS / DAYS
   IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb. 20, 1944
8. BIRTHPLACE (State or Foreign Country): MAryland
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF OEATH: B

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 5034 Erdman Ave.
10f. ZIP CODE: 21205
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY: ECC Contractors
17. FATHER'S NAME (First, Middle, Last): William Cook Sr.
16. MOTHER'S NAME (First, Middle, Maiden Surname): Lorraine Everhart
19a. INFORMANT'S NAME (Type/Print): Anna Cook
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5034 Erdman Ave. BAltimore MAryland 21205
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Oak LAwn CEmetery DATE: 4/2/92
20c. LOCATION — City or Town, State: BAltimore Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home
22. NAME AND ADDRESS OF FACILITY: ConnellyFuneral Home 300MAceAve. 21221

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Hepatic failure
DUE TO (OR AS A CONSEQUENCE OF):
c. Multiple liver disease
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
marine & I bleed with portal hypertension
SICPS/S

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD Ryden
29c. LICENSE NUMBER: D40609
29d. DATE SIGNED (Month, Day, Year): 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NOELLA MISQUITH c/o Dept of Medicine FRANCIS SCOTT KEY MEDICAL CENTER
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

4

92 09011

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Annie Dollar
2. DATE OF DEATH (Month, Day, Year): March 28 1992
3. TIME OF DEATH: 9:30 p M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 67 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5 -9-24
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3003 W. Northern Parkway
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): John Dollar
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ann Manning
19a. INFORMANT'S NAME (Type/Print): Donald Graham
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3226 Avondale Ave. Balto.,MD. 21215
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem. Park — DATE: 4-2-92
20c. LOCATION — City or Town, State: Arbutus ,MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Doretha Hector #281
22. NAME AND ADDRESS OF FACILITY: E.L.Phillips F/H 1721-27 N.Monroe St. Balto.,MD. 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infaction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. End Stage Renal Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Sepsis (As Per History)	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: n/a
29d. DATE SIGNED (Month, Day, Year): ▶ 3/28/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Tamas Kocsis, M.D. c/o Maryland General Hospital 827 Linden Avenue
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09012

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VINCENT D'ANGELO					2. DATE OF DEATH (Month, Day, Year): MARCH 30, 1992	3. TIME OF DEATH: 12:15 P. M
4. SOCIAL SECURITY NUMBER: 213-12-8439	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): SEPT.12,1919	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 7417 LESADA DRIVE			9b. CITY, TOWN OR LOCATION OF DEATH: WOODLAWN			9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: WOODLAWN	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO
10e. STREET AND NUMBER: 7417 LESADA DRIVE APT. 2A		10f. ZIP CODE: 21207	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XX YES 2 ☐ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HAIR STYLIST	16b. KIND OF BUSINESS/INDUSTRY: SELF-EMPLOYED	
17. FATHER'S NAME (First, Middle, Last): SALVATORE D'ANGELO		18. MOTHER'S NAME (First, Middle, Maiden Surname): ADELINA R. MAGGIO	
19a. INFORMANT'S NAME (Type/Print): MICHAEL D'ANGELO (SON)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 656 LEAR STREET, ORLANDO, FLORIDA 32809	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY	DATE: 4/1/92	20c. LOCATION — City or Town, State: CATONSVILLE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Russell C. Witzke	22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Respiratory Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Obstructive Pulmonary Disease + Emphysema	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Herman Brecher M.D.	29c. LICENSE NUMBER: DO 1317	29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HERMAN BRECHER M.D. 6410 WINDSOR MILL ROAD, BALTIMORE, MARYLAND 21207

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

25f1

92 09013

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM FRANCIS DOYLE / William Doyle	2. DATE OF DEATH (Month, Day, Year): 3 30 1992	3. TIME OF DEATH: 0620 A.M.		
4. SOCIAL SECURITY NUMBER: 212-10-5732	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/08/15	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Extended Care Unit	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: N/A		

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1514 Fernley Road	10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: XXXX WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Safety Instructor	16b. KIND OF BUSINESS/INDUSTRY: Trucking	
17. FATHER'S NAME (First, Middle, Last): XXXX William Doyle	18. MOTHER'S NAME (First, Middle, Maiden Surname): XXXXX Anne Hathaway		
19a. INFORMANT'S NAME (Type/Print): Dorothy E. Doyle	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1514 Fernley Road Baltimore Maryland XX 21218		
20a. METNOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) XXX	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory; DATE: 3/31	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: G. Joseph Ferrarse M00203	22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Esophageal Carcinoma DUE TO (OR AS A CONSEQUENCE OF):	5 mon.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles Padgett, MD	29c. LICENSE NUMBER: D15546	29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles Padgett MD, 5601 Loch Raven Blvd. Baltimore, MD 21239

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE

DNMN-16 Rev 1/89

92 09014

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dorothy Grace Doss (Dorothy Doss)			2. DATE OF DEATH (Month, Day, Year): 3 28 92	3. TIME OF DEATH: 8 45 AM
4. SOCIAL SECURITY NUMBER: 213-64-0599	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 39 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 01-28-1953	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: -------

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Joppa	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1008 Erwin Drive		10f. ZIP CODE: 21085	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): +3		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Unemployed	16b. KIND OF BUSINESS/INDUSTRY: Disabled
17. FATHER'S NAME (First, Middle, Last): Luther James Doss, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Safewright	
19a. INFORMANT'S NAME (Type/Print): Dorothy S. Doss		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1008 Erwin Drive; Joppa, Md. 21085	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Mem. Pk. DATE: 3-31-92	20c. LOCATION — City or Town, State: Elkridge, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F. Hackman Jr.		22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home 3204 Mountain Road; Pasadena, Md. 21122	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Respiratory Failure — 3/21/92
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pulmonary Fibrosis
DUE TO (OR AS A CONSEQUENCE OF):
c. Scleroderma
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Sepsis

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia Ryder, MD — Resident, Int. Medicine	29c. LICENSE NUMBER: D40609	29d. DATE SIGNED (Month, Day, Year): 3/28/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia Ryder, MD 4940 Eastern Ave, FSKMC, Balto MD 21224			
31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall		

DHMH-16 Rev 1/89

10

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09015 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Beauford Russell Dott (Beauford Dott)

2. DATE OF DEATH (Month, Day, Year): 03 28 92

3. TIME OF DEATH: 5:30 P M

4. SOCIAL SECURITY NUMBER: 387-09-0869

5. SEX: 1 ☑ M 2 ☐ F

6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7. DATE OF BIRTH (Month, Day, Year): June 15, 1912

8. BIRTHPLACE (State or Foreign Country): Wisconsin

9a. FACILITY NAME (If not institution, give street and number): Church Home Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY: BAltimore

10c. CITY, TOWN OR LOCATION: Middle River

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 3708 C White Pine Road

10f. ZIP CODE: 21220

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Quality Engineer

16b. KIND OF BUSINESS/INDUSTRY: Federal Goverment

17. FATHER'S NAME (First, Middle, Last): Henry Pott

18. MOTHER'S NAME (First, Middle, Maiden Surname): Adelia Cunitz

19a. INFORMANT'S NAME (Type/Print): Anna Dott

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3708 C White Pine Road BAltimore Md. 21220

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Cemetery — DATE: 3/31/92

20c. LOCATION — City or Town, State: Baltimore Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home

22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MAceAve. 21221

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiec or reepiratory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel diseese or condition resulting in deeth) →
a. Cancer of Colon
DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury thet initieted events resulting in deeth) LAST
b. Diabetes Mellitus
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kevin Cleary House Officer

29c. LICENSE NUMBER: D38943

29d. DATE SIGNED (Month, Day, Year): 3/28/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kevin Cleary 20 S. Greene st Balt MD 21201

31. DATE FILED (Month, Day, Year): MAR 31 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09016

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James L. Ellis			2. DATE OF DEATH (Month / Day / Year): 3 / 25 / 92	3. TIME OF DEATH: 1245 AM
4. SOCIAL SECURITY NUMBER: 243-16-5076	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 70 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 8/2/1921	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): 15 Bon Air Road		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 15 Bon Air Road		10f. ZIP CODE: 21225	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: World War II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction	16b. KIND OF BUSINESS/INDUSTRY: Iron - Local 16	
17. FATHER'S NAME (First, Middle, Last): Otis Ellis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ruth Ethridge	
19a. INFORMANT'S NAME (Type/Print): Elnora Ellis	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 Bon Air Road Baltimore, Maryland 21225		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Loudon Park Cemetery	DATE: 3-27	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard E Davis	22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Colon Ca	2yrs 4mos.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one). HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year); 26b. TIME OF INJURY M; 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dorothy Snow	29c. LICENSE NUMBER: D24149	29d. DATE SIGNED (Month, Day, Year) ▶ 3/25/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dorothy Snow VAMC 3900 Loch Raven Blvd, Balto 21218

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

8+1

92 09017

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROSETTA FRAZIER			2. DATE OF DEATH — MONTH: 03 DAY: 27 YEAR: 92	3. TIME OF DEATH: 7:31 pM
4. SOCIAL SECURITY NUMBER: 212-30-2939	5. SEX: 1 ☐ M 2 XX F	6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5-16-35	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 236 S. SPRING COURT		10f. ZIP CODE: 21231	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 10th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABLED	16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): JAMES JOHNSON	18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN JOHNSON	
19a. INFORMANT'S NAME (Type/Print): HELEN BOONE	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 404 PITTMAN PLACE/BALTIMORE, MD 21202	
20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): ARBUTUS MEMORIAL PARK — DATE:	20c. LOCATION — City or Town, State: ARBUTUS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lynette K. Jones	22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS	48°
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. WOUND INFECTION	96°
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. POSTERIOR SPINAL FUSION AND INSTRUMENTATION 3/17/92	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. DEGENERATIVE DISC DISEASE	4 YEARS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES
OBESITY

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A — 28b. TIME OF INJURY: N/A M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED: N/A — 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D42168	29d. DATE SIGNED (Month, Day, Year): ▶ 3/27/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN KINSELLA, MD JHH, BALTIMORE, MD 21205		
31. DATE FILED (Month, Day, Year): 3/27/92	32. REGISTRAR'S SIGNATURE: MAR 31 1992 Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-18 Rev 1/89

92 09018

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FOSTER E JAMES (JAMES EDWARD FOSTER)			2. DATE OF DEATH (Month, Day, Year): 3 25 92	3. TIME OF DEATH: 4 00 A M
4. SOCIAL SECURITY NUMBER: 217262281	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1-21-31	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Columbia		9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 5035 Montgomery Rd.		10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): unknown College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Auto Mechanic	16b. KIND OF BUSINESS/INDUSTRY: City Oldsmobile	
17. FATHER'S NAME (First, Middle, Last): James Mathelius Foster		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nora Lucille Shifflett	
19a. INFORMANT'S NAME (Type/Print): Grace E. Foster		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5035 Montgomery Rd. Ellicott City, Md. 21043	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Good Shepard Cemetery	20c. LOCATION — City or Town, State: Ellicott City, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home P. O. Box 268 Ellicott City, Md	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Congestive heart failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Coronary artery disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. pneumonia	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Vomiting Possible bowel obstruct; bilateral cerebral vascular accident

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H. Tamorsalli MD	29c. LICENSE NUMBER: D18484	29d. DATE SIGNED (Month, Day, Year): ▶ 3/25/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. H. TAMBASCLIE. 3455 WILKENS AVE. BALT. MD 21229		
31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall	

DHMH-16 Rev 1/89

92-1782-003 Items: 23 part I,27,28a,b,c,d,e,f per MEO 92 09019

1 - FOR STATE REGISTRAR G-686 4/1/92 reb

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be completed and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FREDERICK JOSEPH FLANAGAN				2. DATE OF DEATH (Month, Day, Year): 03 27 1992	3. TIME OF DEATH: 7:05 A.M
4. SOCIAL SECURITY NUMBER: 100-60-6734	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 27 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): OCT. 24, 1964	8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: ANNE ARUNDEL
RESIDENCE OF DECEDENT					
10a. STATE: MD.	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: GLEN BERNIE			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 225 KUETHE ROAD			10f. ZIP CODE: 21061		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA; College (1-4 or 5 +): NA		16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY: SELF -EMPLOYED	
17. FATHER'S NAME (First, Middle, Last): RALPH ALTON FLANAGAN			18. MOTHER'S NAME (First, Middle, Maiden Surname): RUTH E. BORONSKI		
19a. INFORMANT'S NAME (Type/Print): KEVIN W. FLANAGAN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7432 FURNACE BRANCH RD. GLEN BERNIE, MD. 21061			
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory, or other place): ST. MATTHEWS CEMETERY DATE: 3/31/92		20c. LOCATION — City or Town, State: CHESTER SPRINGS, PA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Wm H Fuller		22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 9705 BELAIR ROAD BALTO, MD. 21236			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cocaine intoxication

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [X] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 3/27/92	28b. TIME OF INJURY: 6:41 A.M.	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Unknown
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 225 Kuethe Rd. Glenn Burnie, A.A.Co.Md.

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A M DIXON	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): 03-28-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A M DIXON 111 PENN STREET BALTIMORE MARYLAND 21201		
31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Jackie Davidson-Hamilton	

DHMH-16 Rev 1/89

92 09020

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DORA B ELL FLETCHER			2. DATE OF DEATH: MONTH 03 DAY 26 YEAR 92	3. TIME OF DEATH: 03:02 PM M
4. SOCIAL SECURITY NUMBER: 404 14 3756	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1-30-1914	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel co	10c. CITY, TOWN OR LOCATION:		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: WellspringsHome Furnace Branch Rd		10f. ZIP CODE:		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker/Wiring		16b. KIND OF BUSINESS/INDUSTRY: Keystone Electric
17. FATHER'S NAME (First, Middle, Last): Floyd Richard Holmes			18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Elizabeth Carola	
19a. INFORMANT'S NAME (Type/Print): Larry Chappell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8060 WoodHolm Circle, Pasadena, MD21122		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir 3/30/92		22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD 655 W. Baltimore St, Balto., MD 2120		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
b. Intra abdominal infection
DUE TO (OR AS A CONSEQUENCE OF):
c. Massive Gangrene of Small Bowel, Status
DUE TO (OR AS A CONSEQUENCE OF):
d. Post Resection

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Rheumatic Heart Disease with Atrial Fibrillation
Alzheimers Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Chrysanthemum Attending Doctor	D21694	▶ 3/25/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CHACKUMKAL V. CYRIAC, M.D./1600 CRAIN HIGHWAY, SW, #308/GLEN BURNIE, MARYLAND 21061

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 30 1992	

DHMH-16 Rev 1/89

92 09021

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~BEA~~ BEULAH GREEN
2. DATE OF DEATH (Month, Day, Year): 3-27-92
3. TIME OF DEATH: 9:37 A M
4. SOCIAL SECURITY NUMBER: 218-16-1779
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6-9-07
8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): MERIDIAN NURSING HOME
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5706 LOCH RAVEN BLVD. APT. C
10f. ZIP CODE: 21239
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENOENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 6th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF EMPLOYED
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): PHILLIP TURNER
18. MOTNER'S NAME (First, Middle, Maiden Surname): MAGGIE
19a. INFORMANT'S NAME (Type/Print): WILLIE GREEN
19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5706 LOCH RAVEN BLVD./BALTIMORE, MD 21239
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND OATE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK — OATE:
20c. LOCATION — City or Town, State: ARBUTUS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastatic Cancer Breast
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pleural effusion
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF OEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Suresh Tripuraneni
29c. LICENSE NUMBER: D30661
29d. OATE SIGNED (Month, Day, Year): ▶ 3/28/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SURESH TRIPURANENI 5706 LOCH Raven BLVD Md-21234
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

4

92 09022

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VIRGINIA LAYMAN GILMORE				2. DATE OF DEATH: MONTH 3 DAY 30 YEAR 92	3. TIME OF DEATH: 1838 M
4. SOCIAL SECURITY NUMBER: 166 07 3763	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10-17-1914	8. BIRTHPLACE (State or Foreign Country): PENNA
9a. FACILITY NAME (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY		9c. COUNTY OF DEATH: WICOMICO
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Wicomico County	10c. CITY, TOWN OR LOCATION: Salisbury			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 413 Deborah Drive		10f. ZIP CODE: 21801		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: no	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 + ; College (1-4 or 5+): 3	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY: Homemaker			
17. FATHER'S NAME (First, Middle, Last): IRWIN LAYMAN	16. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET				
19a. INFORMANT'S NAME (Type/Print): David John Gilmore Husb	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 413 Deborah Dr, Salisbury, MD 21801				
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir 3/31/92	22. NAME AND ADDRESS OF FACILITY: STATE ANTOMY BOARD 655 W.BaltimoreST, Balto.MD 21201				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
M B Horner MD	D13053	▶ 3/30/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 31 1992	Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anthony Francis Greenfield, Sr.
2. DATE OF DEATH (Month, Day, Year): 03 - 28 - 92
3. TIME OF DEATH: 12:00 PM
4. SOCIAL SECURITY NUMBER: 217-20-2968
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 65 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 09-10-1926
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: --------

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Glen Burnie
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 864 N. Shore Drive
10f. ZIP CODE: 21060
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): +2
16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Master Auto. Mech.
16b. KIND OF BUSINESS/INDUSTRY: Armor Tread Tire Co.
17. FATHER'S NAME (First, Middle, Last): Nelson Joesph Greenfield
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Marie Bechler
19a. INFORMANT'S NAME (Type/Print): Mae E. Greenfield
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 864 N. Shore Drive; Glen Burnie, Md. 21060
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cem. DATE: 4-1-92
20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F. Hackman Jr.
22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home, 3204 Mountain Rd., Pasadena, Md. 21122

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebrovascular Accident — Approximate Interval: 5 days
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Dementia — Approximate Interval: 2 yrs
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Afroze Muneer MD intern
29c. LICENSE NUMBER: AS24416142
29d. DATE SIGNED (Month, Day, Year): 3/28/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. A. MUNEER 30001 S. HANOVER STREET BALTIMORE MD 21225
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [illegible] by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hyman H. Goldberg		2. DATE OF DEATH (Month, Day, Year): 3-27-1992	3. TIME OF DEATH: 8:25 PM M
4. SOCIAL SECURITY NUMBER: 116-03-5807	5. SEX: 1 X M 2 ☐ F	8. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1-28-06
8. BIRTHPLACE (State or Foreign Country): Canada			
9a. FACILITY NAME (If not institution, give street and number): Hebrew Home of Wash. D.C.	9b. CITY, TOWN OR LOCATION OF DEATH: Rockville	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 6121 Montrose Road		10f. ZIP CODE: 20852	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman	16b. KIND OF BUSINESS/INDUSTRY: Shoes

17. FATHER'S NAME (First, Middle, Last): David Goldberg	18. MOTHER'S NAME (First, Middle, Maiden Surname): Dora (unascertainable)
19a. INFORMANT'S NAME (Type/Print): Nellie Goldberg	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7848 Jacobs Drive, Greenbelt, Maryland 20770

20a. METHOD OF DISPOSITION: X 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Lebanon Cemetery 3/29/1992	20c. LOCATION — City or Town, State: Adelphi, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▸Donald C. Stottlemyer	22. NAME AND ADDRESS OF FACILITY: STEIN HEBREW MEMORIAL FUNERAL HOME, Inc. 232 CARROLL STREET, N.W., WASHINGTON, D.C.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SUDDEN DEATH - MYOCARDIAL INFARCTION	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS / PNEUMONIA
SEVERE MULTI-INFARCT DEMENTIA

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	28. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	26d. DESCRIBE HOW INJURY OCCURED		
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Alvin S. Madarang, MD	29c. LICENSE NUMBER: D39166	29d. DATE SIGNED (Month, Day, Year): ▸ 3/28/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALVIN S. MADARANG, MD 6121 MONTROSE RD ROCKVILLE, MD 20852.		
31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Richard GOULD Jr.			2. DATE OF DEATH (Month, Day, Year): March 26, 1992	3. TIME OF DEATH: 3:08PM M
4. SOCIAL SECURITY NUMBER: 199-12-2368	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 2, 1925	8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Rossville		9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: BAltimore	10c. CITY, TOWN OR LOCATION: Essex	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 93 Langley Road		10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2yr	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-employed	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Richard James Gould Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lela Chamberlain	
19a. INFORMANT'S NAME (Type/Print): Ed Gould		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 313 Lorraine Ave. Baltimore MD. 21221	

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): SacredHeartofJesusCem.	DATE: 3/30/92	20c. LOCATION — City or Town, State: BAltimore Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home		22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MAceAve. 21221	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiec or reapiratory errest, shock, or heer(failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

History of several myocardial infarctions
Status-post Coronary Artery Bypass-8 years
Hypertension Disease

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
[X] 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[ ] 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gabriel Soudry M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 3/26/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Gabriel Soudry 9000 Franklin Square Drive - 21237		
31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Neva Annabelle Herron

2. DATE OF DEATH (Month, Day, Year): March 28, 1992

3. TIME OF DEATH: 12:30 P M

4. SOCIAL SECURITY NUMBER: 213-34-7890

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 57 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Jan. 7, 1935

8. BIRTHPLACE (State or Foreign Country): Tennessee

9a. FACILITY NAME (If not institution, give street and number): 1000 Armistead Way

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH: - - - -

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: - - - -

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 1000 Armistead Way

10f. ZIP CODE: 21205

10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): NA
College (1-4 or 5+): NA

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator

16b. KIND OF BUSINESS/INDUSTRY: Poly Seal Corp.

17. FATHER'S NAME (First, Middle, Last): Russell Edward Manuel Sr.

18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Marie Taylor

19a. INFORMANT'S NAME (Type/Print): Deborah Saver (Dghtr)

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2803 Glendale Ave., Baltimore, Md. 21234

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery — DATE:

20c. LOCATION — City or Town, State: Baltimore, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Eugene J. Lastner Jr.

22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Homes, Inc.
3331 Brehms Lane, Baltimore, Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary Emphysema DUE TO (OR AS A CONSEQUENCE OF):	10 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Portell

29c. LICENSE NUMBER: 011714

29d. DATE SIGNED (Month, Day, Year): 3/30/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Michael Portell, Francis Scott Key, 4940 Eastern Ave., Balto, Md. 21224

31. DATE FILED (Month, Day, Year): MAR 31 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09027

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN C. HONEYCUTT					2. DATE OF DEATH (Month, Day, Year): MARCH 28, 1992	3. TIME OF DEATH: 11:48 P. M
4. SOCIAL SECURITY NUMBER: 234-24-6726	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JULY 25, 1911	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): 8220 MISSION ROAD			9b. CITY, TOWN OR LOCATION OF DEATH: JESSUP		9c. COUNTY OF DEATH: HOWARD	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: HOWARD	10c. CITY, TOWH OR LOCATION: JESSUP	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO
10e. STREET AND NUMBER: 8220 MISSION ROAD		10f. ZIP CODE: 20794	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FACTORY WORKER	16b. KIND OF BUSINESS/INDUSTRY: ELECTRICAL APPLIANCE	
17. FATHER'S NAME (First, Middle, Last): EMORY HONEYCUTT		18. MOTHER'S NAME (First, Middle, Maiden Surname): MATTIE DeBOARD	
19a. INFORMANT'S NAME (Type/Print): GLENDA USERY (DAUGHTER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8220 MISSION ROAD, JESSUP, MARYLAND 20794	
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): MEADOWRIDGE MEMORIAL PARK DATE: 4/1/92	20c. LOCATION — City or Town, State: DORSEY, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD, COLUMBIA, MARYLAND	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Prostate Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D21787	29d. DATE SIGNED (Month, Day, Year): 3/26/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GARY PRADA M.D. 11055 LITTLE PATUXENT PARKWAY, SUITE 104. COLUMBIA, MD. 21045

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

92 09028

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGARET R HALL
2. DATE OF DEATH (Month, Day, Year): 03 26 1992
3. TIME OF DEATH: 530 P M
4. SOCIAL SECURITY NUMBER: 215-24-4783
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 04/25/11
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): CITIZENS NURSING HOME
9b. CITY, TOWN OR LOCATION OF DEATH: HAVRE DE GRACE
9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Harford
10c. CITY, TOWN OR LOCATION: Havre de Grace
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 415 Market Street
10f. ZIP CODE: 21040
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: self
17. FATHER'S NAME (First, Middle, Last): Cleve Collins
18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Whittington
19a. INFORMANT'S NAME (Type/Print): Kenneth Williams
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 92, Bel Camp, Maryland 21017
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery — DATE: 3/30/92
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph J. Ambrose Jr
22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 Sulphur Spr. Rd. Arbutus, Md. 21227

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. HASCVD
DUE TO (OR AS A CONSEQUENCE OF):
c. COPD
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John D. Yun M.D.
29c. LICENSE NUMBER: 021900
29d. DATE SIGNED (Month, Day, Year): ▶ 3/27/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN D. YUN Havre de Grace, MD
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09029
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): RAYMOND W. HORNER

2. DATE OF DEATH (Month, Day, Year): 03 25 92 — 03-25-92

3. TIME OF DEATH: 4:25 P.M

4. SOCIAL SECURITY NUMBER: 404 07 8531

5. SEX: 1 [XX] M 2 [ ] F

6. AGE (In yrs. last birthday): 79 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 08 14 1912

8. BIRTHPLACE (State or Foreign Country): Ohio

9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Towson

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Towson

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [XX] NO

10e. STREET AND NUMBER: 108 Kenilworth Park Dr. Apt 1B Towson, MD

10f. ZIP CODE: 21204

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married [XX] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— it yes, specify Cuben, Mexican, Puerto Ricen, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indien, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician

16b. KIND OF BUSINESS/INDUSTRY: I.B.E.W. Local #24

17. FATHER'S NAME (First, Middle, Last): George Horner

18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruhama Collingsworth

19a. INFORMANT'S NAME (Type/Print): Louise L. Horner

19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code): Same as 10e

20a. METHOD OF DISPOSITION: [XX] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, crematory or other piece): Lorraine Park Cemetery 3-28-92

20c. LOCATION — City or Town, State: Woodlawn, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Douglas C Menapace

22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home 1050 York Rd. Towson, MD 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such es cerdiec or reepiratory errest, shock, or heert feilure. List only ona cause on each line.

Approximate Intervsl Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Chronic obstructive pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF OEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

28. PLACE OF OEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

26a. OATE OF INJURY (Month, Day, Year)

26b. TIME OF INJURY M

26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

26d. DESCRIBE HOW INJURY OCCURED

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
[XX] 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner ee stated.
[ ] 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) end manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Natividad D. de Leon, M.D.

29c. LICENSE NUMBER: D19508

29d. DATE SIGNED (Month, Day, Year): 3/25/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NATIVIDAD D. DE LEON C/O ST. JOSEPH HOSPITAL, TOWSON, MD. 21204

31. DATE FILED (Month, Day, Year): MAR 31 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Ritchie

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09030
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna B Hickman / ANNA B. HICKMAN			2. DATE OF DEATH (Month, Day, Year): 3 22 92	3. TIME OF DEATH: 6 45 A M
4. SOCIAL SECURITY NUMBER: 216-28-9244	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 29, 1911	8. BIRTHPLACE (State or Foreign Country): Alabamma
9a. FACILITY NAME (If not institution, give street and number): Westminister Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Westminister	9c. COUNTY OF DEATH: Carroll	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminister	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1234 Washington Road		10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Benjamin Weathers		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jessie UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): Mrs. Eunice V. Kavanagh		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 105 Stanmore Road, Baltimore, Md. 21212	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park DATE: 3-30-92	20c. LOCATION — City or Town, State: Parkville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks Jr.		22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md 21204	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio Vascular disease	years ~?or?
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASHD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William R Mourlee	29c. LICENSE NUMBER: D09389	29d. DATE SIGNED (Month, Day, Year): ▶ 3/27/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

OHMH-16 Rev 1/89

92 09031

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louise Harris,

2. DATE OF DEATH (Month, Day, Year): 3 - 27 - 92

3. TIME OF DEATH: 9:25 pM

4. SOCIAL SECURITY NUMBER: 243-32-0832

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 71 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 3-17-21

8. BIRTHPLACE (State or Foreign Country): North Carolina

9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Balto

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 816 Brooks Lane

10f. ZIP CODE: 21117

10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)

16b. KIND OF BUSINESS/INDUSTRY: Maritime Inst.

17. FATHER'S NAME (First, Middle, Last):

18. MOTHER'S NAME (First, Middle, Maiden Surname): Calleana White

19a. INFORMANT'S NAME (Type/Print): Augustine G. Russell

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4905 I Columbia Rd Columbia Md 21044

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem Park — DATE: 4/92

20c. LOCATION — City or Town, State: Arbutus, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Martin Elbron

22. NAME AND ADDRESS OF FACILITY: March FH. West 4300 Wabash Ave

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastatic Colon CA.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER:

29c. LICENSE NUMBER: D37949

29d. DATE SIGNED (Month, Day, Year): 3/27/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Baltimore County General Hospital, 5401 Old Court Rd, Randallstown, MD

31. DATE FILED (Month, Day, Year): MAR 31 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09032

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ORANDA HARDING (Oranga Harding)
2. DATE OF DEATH: MONTH 3 DAY 27 YEAR 92
3. TIME OF DEATH: 1017 A M
4. SOCIAL SECURITY NUMBER: 213 86 4097
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 46 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): August 26, 1945
8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): University Of Maryland Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH (City): BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Pasadena
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 580 A St.
10f. ZIP CODE: 21122
10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: American Indian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary
16b. KIND OF BUSINESS/INDUSTRY: Construction Co.
17. FATHER'S NAME (First, Middle, Last): Raymond Shaves, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Inez Revels
19a. INFORMANT'S NAME (Type/Print): Carl Harding
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 580 A. St., Pasadena, MD 21122
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Pk. — DATE: 4/3/92
20c. LOCATION — City or Town, State: Glen Burnie, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stephen D. Shumm
22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena, 3204 Mountain Rd., Pasadena, MD 21122

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. BRAIN DEATH
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. INTRACEREBRAL HEMMORRHAGE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 3/25/92
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: T Knuth
29c. LICENSE NUMBER: D42195
29d. DATE SIGNED (Month, Day, Year): 3/27/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THOMAS E. KNUTH, MD MIEMSS SHOCK TRAUMA BALTIMORE, MD 20201
31. DATE FILED (Month, Day, Year): MAR 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson Rodella

DHMH-16 Rev 1/89

6

92 09033

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby (Male) HOPKINS					2. DATE OF DEATH: MONTH 3 DAY 18 YEAR 92	3. TIME OF DEATH: 9:30 P. M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 0 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS 2 / MIN. 0	7. DATE OF BIRTH (Month, Day, Year): 3-18-92	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: Baltimore City	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie, Maryland	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1601 Kimber Road		10f. ZIP CODE: 21060	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Mulatto

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A	16b. KIND OF BUSINESS/INDUSTRY: N/A	
17. FATHER'S NAME (First, Middle, Last): Arnell Michael Davis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Gloria Junita Thomas	
19a. INFORMANT'S NAME (Type/Print): Gloria J. Hopkins		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1601 Kimber Road	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify): In state City Disposition	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State: Baltimore
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir 3/27/92		22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD 655 W. BaltimoreSt,Balto.,MD 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Intervel Between Onset end Deeth

IMMEDIATE CAUSE (Final diseese or condition resulting in death) →
a. Non-viable fetus (495Gm)
DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mustafa Onal M.D.	29c. LICENSE NUMBER: D0 9400	29d. DATE SIGNED (Month, Day, Year): ▶ 3/18/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mustafa ONAL		
31. DATE FILED (Month, Day, Year): MAR 30 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09034
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lenzie M Johnson SR.
2. DATE OF DEATH — MONTH: 03 DAY: 27 YEAR: 92
3. TIME OF DEATH: 0535 M
4. SOCIAL SECURITY NUMBER: 216-01-3614
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 02-20-1901
8. BIRTHPLACE (State or Foreign Country): VA.

9a. FACILITY NAME (If not institution, give street and number): Lorien Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Columbia, Md
9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 430 E. 21st STREET
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF EMPLOYED
16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): HERBERT JOHNSON
16. MOTHER'S NAME (First, Middle, Maiden Surname): HATTIE PHILLIPS

19a. INFORMANT'S NAME (Type/Print): LENZIE M. JOHNSON, JR.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 430 E. 21st STREET/BALTIMORE, MD 21218

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): JOHNSON FAMILY CEMETERY — DATE:
20c. LOCATION — City or Town, State: SOUTH HILL, VIRGINIA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lynette K. Jones
22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Arteriosclerosis.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia, bed decubiti

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO — N/A.
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D31575
29d. DATE SIGNED (Month, Day, Year): 3/27/92.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KOCH DR GEORGE 6501 Old Annapolis Road Ellicott City MD 21043

31. DATE FILED (Month, Day, Year): MAR 3 1 1992
32. REGISTRAR'S SIGNATURE: [signature]

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lillian Jelks

2. DATE OF DEATH Month: 3 Day: 29 Year: 92

3. TIME OF DEATH: 9:50 PM

4. SOCIAL SECURITY NUMBER: 212-44-8889

5. SEX: 1 ☐ M 2 ☑ F

6. AGE (In yrs. last birthday): 48 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 9/3/43

8. BIRTHPLACE (State or Foreign Country): Md.

9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 116 S. Durham Street

10f. ZIP CODE: 21231

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 11 yrs.
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): Simon McCauley

18. MOTHER'S NAME (First, Middle, Maiden Surname):

19a. INFORMANT'S NAME (Type/Print): Lawrence Jelks

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 116 S. Durham St., Balto., Md. 21231

20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Holly Hill Cemetery — DATE: 3/31

20c. LOCATION — City or Town, State: Balto., Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward F. Jewell

22. NAME AND ADDRESS OF FACILITY: Lilly & Zeiler Inc. 1901 Eastern Ave. 21231

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter tha mode of dying, euch ee cerdiec or reapiratory errest, shock, or heart failure. List only ona cause on eech lina.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disesse or condition resulting in death) → a.	Infarction of the Small Bowel	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequantielly list conditions, if any, leading to immediete cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other signiticent conditiona contributing to death but not reaulting in the underlying cause given in Pert I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Neal M. Friedlander, M.D

29c. LICENSE NUMBER: D28673

29d. DATE SIGNED (Month, Day, Year): 3/28/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NEAL M. FRIEDLANDER, M.D., Prof. Office Bldg, Suite 907, 301 St. Paul Place, Balto, Md 21202

31. DATE FILED (Month, Day, Year): MAR 31 1992

32. REGISTRAR'S SIGNATURE:

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BABY BOY Johnson					2. DATE OF DEATH (Month, Day, Year): March 23, 1992	3. TIME OF DEATH: 5:25pm M
4. SOCIAL SECURITY NUMBER: n/a	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS 1 / MIN. 15	7. DATE OF BIRTH (Month, Day, Year): 3/23/92	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: n / a	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: n/a	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1705 Mount Street		10f. ZIP CODE: 21217	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): n/a	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname): Yvonne Johnson	
19a. INFORMANT'S NAME (Type/Print): YvonneJohnson Medical Records Dept.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Md General Hosp. 827 Linden Ave. Balto., MD.	

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir 3-27-92	22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD 655 W. BaltimoreSt, Balto., MD 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Non-viable 20 week premature male	
	DUE TO (OR AS A CONSEQUENCE OF): Product of a spontaneous abortion	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: [X] 1 Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. Das MD	29c. LICENSE NUMBER: D32132	29d. DATE SIGNED (Month, Day, Year) ▶ 3/23/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. Das, M.D.	c/o Maryland General Hospital	
31. DATE FILED (Month, Day, Year): MAR 30 1992	32. REGISTRAR'S SIGNATURE: Julia Dawson-Jones	

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 9:41 A.M.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie D. Klein

2. DATE OF DEATH (Month, Day, Year): 3 26 92

3. TIME OF DEATH: 0941 AM

4. SOCIAL SECURITY NUMBER: 218-32-3554

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 77 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): SEPT. 27, 1914

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): The Union Memorial Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH: -----

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: -----

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 4779 ELISON AVENUE

10f. ZIP CODE: 21206

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): NA
College (1-4 or 5+): NA

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TAVERN OWNER

16b. KIND OF BUSINESS/INDUSTRY: OWN BUSINESS

17. FATHER'S NAME (First, Middle, Last): JOSEPH KUTZ

18. MOTHER'S NAME (First, Middle, Maiden Surname): FRANCES SZYMANSKI

19a. INFORMANT'S NAME (Type/Print): GEORGE E. KLEIN (SON)

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1610 ROSS RD., FOREST HILL, MARYLAND 21050

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY ROSARY CEMETERY — DATE:

20c. LOCATION — City or Town, State: DUNDALK, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]

22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOMES, INC. 9705 BELAIR ROAD, BALTIMORE, MD 21236

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	myocardial infarction	1°
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	cervical ca s/p exenteration	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	ischemic cardiomyopathy	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURRED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Christopher B Gordon MD Union Memorial Hosp 201 E University Pkwy Bal MD 21218

31. DATE FILED (Month, Day, Year): MAR 31 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Regina M. Koontz			2. DATE OF DEATH (Month, Day, Year): 03 30 1992	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 216 18 4230	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9/5/1918	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 682 Duvall Highway		9b. CITY, TOWN OR LOCATION OF DEATH: Pasadena		9c. COUNTY OF DEATH: Anne Arundel
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Pasadena		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 682 Duvall Highway		10f. ZIP CODE: 21122		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cashier		16b. KIND OF BUSINESS/INDUSTRY: Department Store
17. FATHER'S NAME (First, Middle, Last): Leonard Rowe		18. MOTHER'S NAME (First, Middle, Maiden Surname): Regina Walters		
19a. INFORMANT'S NAME (Type/Print): Charles A. Koontz		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 682 Duvall Highway Pasadena, Maryland 21122		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery DATE: 4-2		20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard C Davis		22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reepiratory errest, ehock, or heert feilure. Liet only one ceuee on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Cardiorespiratory Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST	b. Brain metastases	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Small cell lung cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, end due to the ceuse(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D33472	▶ 3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Howard Parnes UMCC 22 S Greene St Balto, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 31 1992	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09039

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HAZEL GERALDINE KOUGH				2. DATE OF DEATH (Month, Day, Year): 3 - 27 - 92	3. TIME OF DEATH: 330 A M
4. SOCIAL SECURITY NUMBER: 210-24-7211	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): December 15, 1908	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: ----------N/A---

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8602 Chestnut Oak Road		10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+): 4 years	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Credit Analyser	16b. KIND OF BUSINESS/INDUSTRY: May Company	
17. FATHER'S NAME (First, Middle, Last): Daniel Miles Kough		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Mae David	
19a. INFORMANT'S NAME (Type/Print): Charles R. Hechler	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8610 Chestnut Oak Road Balto., MD 21234		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery	DATE: 3/30	20c. LOCATION — City or Town, State: Parkville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Cori L. Ebaugh	22. NAME AND ADDRESS OF FACILITY: Johnson Funeral Home Balto., MD 8521 Loch Raven Blvd. 21204		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. chronic obstructive pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
congestive heart failure
renal failure

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C Schoedel M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 3/27/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C Schoedel 301 St Paul Pl Baltimore MD 21202

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92-1757-510

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09040

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHY RAY LURCH				2. DATE OF DEATH (Month, Day, Year): 03 26 1992	3. TIME OF DEATH: 2:56 A.M	
4. SOCIAL SECURITY NUMBER: 213-66-9512	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 37 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 25, 1954	8. BIRTHPLACE (State or Foreign Country): Maryland	
9a. FACILITY NAME (If not institution, give street and number): 923 S. LINWOOD AVE				9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH: - - - -	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: - - - -		10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 1023 Hewitt Way			10f. ZIP CODE: 21205		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA; College (1-4 or 5+): NA			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Television Service Clerk		16b. KIND OF BUSINESS/INDUSTRY: T. V.	
17. FATHER'S NAME (First, Middle, Last): Raymond F. Munk			18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Mildred Detrick			
19a. INFORMANT'S NAME (Type/Print): Gary Steven Lurch (Husband)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Mars Road, Apt. F, Essex, Md. 21221			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory Inc.	DATE	20c. LOCATION — City or Town, State: Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE			22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Seizure Disorder	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
J. Aaron Locke MD	O.C.M.E.	▶ 03-26-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. AARON LOCKE M.D. 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 31 1992	Gina Davidson-Kendall

DHMH-16 Rev 1/89

10

92 09041

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mildred Regina Liberto		2. DATE OF DEATH (Month, Day, Year): 3-26-92	3. TIME OF DEATH: 6:40 P M
4. SOCIAL SECURITY NUMBER: 219-01-5231	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 9, 1910
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Rt 1 Box 60	9b. CITY, TOWN OR LOCATION OF DEATH: Grasonville	9c. COUNTY OF DEATH: Queen Anne's	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: Queen Anne's	10c. CITY, TOWN OR LOCATION: Grasonville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt 1 Box 60	10f. ZIP CODE: 21638	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yr's; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-Employed	16b. KIND OF BUSINESS/INDUSTRY: Produce	
17. FATHER'S NAME (First, Middle, Last): Charles Dalton	18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Garrity		
19a. INFORMANT'S NAME (Type/Print): Mrs. Monnie Dalton	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6223 McClean Blvd. Baltimore, MD 21214		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith 3/30/92	20c. LOCATION — City or Town, State: Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock, Jr. ▶ Paul L. Hartsock Jr.	22. NAME AND ADDRESS OF FACILITY: Baltimore, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not entar the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIOVASCULAR ACCIDENT	IMMEDIATE
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I.: SEIZURE DISORDER

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D05754	29d. DATE SIGNED (Month, Day, Year): ▶ 3-27-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ralph E. Libby, MD P.O. Box 458 Grasonville, MD 21638

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/69

92 09042

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HAROLD A. LIST

2. DATE OF DEATH (Month, Day, Year): 03 29 92

3. TIME OF DEATH: 300 AM

4. SOCIAL SECURITY NUMBER: 194148112

5. SEX: 1 [X] M 2 [ ] F

6. AGE (If yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 07 08 23

8. BIRTHPLACE (State or Foreign Country): Ohio

9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice

9b. CITY, TOWN OR LOCATION OF DEATH: Towson

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Baltimore City

10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 4505 Roland Ave.

10f. ZIP CODE: 21210

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: W.W.II

13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 4 +

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Professional Engineer

16b. KIND OF BUSINESS/INDUSTRY: Self Empolyeed

17. FATHER'S NAME (First, Middle, Last): George E. List , Jr.

18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen I. Adams

19a. INFORMANT'S NAME (Type/Print): Marie List

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10e

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) / DATE: Misky Hill Cemetery 3/31/92

20c. LOCATION — City or Town, State: Bethlehem , Pa.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ronald C. Shafer Jr.

22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GLIOBLASTOMA

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Carla S. Alexander MD

29c. LICENSE NUMBER: D 27087

29d. DATE SIGNED (Month, Day, Year): ▶ 03 29 92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carla S. Alexander, M.D.-Stella Maris Hospice-Dulaney Valley Rd.-Towson 21204

31. DATE FILED (Month, Day, Year): MAR 3 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09043

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVA KATHERINE LOWRY		2. DATE OF DEATH (Month, Day, Year): 03 29 1992	3. TIME OF DEATH: 9:30 A M
4. SOCIAL SECURITY NUMBER: 214-14-0855	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-21-13
8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA			
9a. FACILITY NAME (If not institution, give street and number): 6217 ORCHARD ROAD	9b. CITY, TOWN OR LOCATION OF DEATH: LINTHICUM	9c. COUNTY OF DEATH: ANNE ARUNDEL	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: LINTHICUM	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6217 ORCHARD RD.	10f. ZIP CODE: 21090	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PUBLIC HEALTH NURSE	16b. KIND OF BUSINESS/INDUSTRY: BALTIMORE CITY	
17. FATHER'S NAME (First, Middle, Last): JOHN WILLIAM VIRT	18. MOTHER'S NAME (First, Middle, Maiden Surname): ADA WOLVERTON		
19a. INFORMANT'S NAME (Type/Print): ELEANOR M. TITUS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 456 9th AVE. HUNTINGTON, W. VIRGINIA 25701		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) ENTOMBMENT	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY	20c. LOCATION — City or Town, State: / 4-1-92 BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Arteriosclerotic Cardio Vascular Disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
c. Continuous Smoking
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Osteo degenerative Arthritis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D62519
29d. DATE SIGNED (Month, Day, Year): ▶ 3-30-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard E Fisher MD Crain Towers, Glen Burnie

31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: [signature]

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12

92-1789-510 Unknown 92-64

92 09044

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LAURA RUTH LAUPUS
2. DATE OF DEATH (Month, Day, Year): 3 28 92
3. TIME OF DEATH: 1:45 A.M
4. SOCIAL SECURITY NUMBER: 223-88-3108
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 37 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 08/25/54
8. BIRTHPLACE (State or Foreign Country): Michigan
9a. FACILITY NAME (If not institution, give street and number): 21231 525 S. Washington Street
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: ---

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: ---
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 525 S. Washington Street
10f. ZIP CODE: 21231
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Writer/Artist
16b. KIND OF BUSINESS/INDUSTRY: Art & Literature
17. FATHER'S NAME (First, Middle, Last): William E. Laupus
18. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn Fike
19a. INFORMANT'S NAME (Type/Print): William E. Laupus
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1873-L Quail Ridge Rd. Greenville, NC 27858
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Metro Crematory, Inc. — DATE: 3/31
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb
22. NAME AND ADDRESS OF FACILITY: Cremation Society of Md., Inc. 299 Frederick Rd. Balto., MD 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Smoke Inhalation
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): Found 3-28-92
28b. TIME OF INJURY: Found 1:45A. M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: Victim of House Fire
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 525 S. Washington St.

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. DIXON
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): 3-28-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE

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92-1774-005

Items 23 Part I,II,27,28a,b,c,d,e,f per MEO, G-686, 4/17/92 gn

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09045 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Burdsall Norman Miller

2. DATE OF DEATH (Month, Day, Year): 3 26 92

3. TIME OF DEATH: 7:45 P.M

4. SOCIAL SECURITY NUMBER: 219-58-5657

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 41 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 08-21-1950

8. BIRTHPLACE (State or Foreign Country): Ohio

9a. FACILITY NAME (If not institution, give street and number): 147 T-8 Nunnery Lane

9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore Co.

10c. CITY, TOWN OR LOCATION: Catonsville

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 147 T-8 Nunnery Lane

10f. ZIP CODE: 21228

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: Vietnam Era

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Counselor

16b. KIND OF BUSINESS/INDUSTRY: Hospital/Health Dept.

17. FATHER'S NAME (First, Middle, Last): Burdsall Dunham Miller

18. MOTHER'S NAME (First, Middle, Maiden Surname): Anne Czarnecki

19a. INFORMANT'S NAME (Type/Print): Ms. Barbara D. Miller

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1402 Midvale Avenue, Catonsville, MD 21228

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore-Washington Cre. DATE: 4/1/92

20c. LOCATION — City or Town, State: Laurel, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00535

22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home, Ellicott City, Maryland 21043

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute propanolol intoxication
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic pancreatitis and diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): Found 3-26-92

28b. TIME OF INJURY: unknown M

28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO

28d. DESCRIBE HOW INJURY OCCURED: Subject took drug

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Found at home

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 147T-8 Nunnery Lane Catonsville, MD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: O.C.M.E.

29d. DATE SIGNED (Month, Day, Year): 3-27-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARGARITA D. KORTE 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): MAR 31 1992

32. REGISTRAR'S SIGNATURE: [signature]

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09046
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or if item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VERA ELMYRA METZLER			2. DATE OF DEATH (Month, Day, Year): 3 26 92	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 220-22-7390	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1-20-16	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: GLEN BURNIE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 508 GLEN VIEW AVE.		10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): NONE	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): AUGUST LEHNERT		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY E. EDLER	
19a. INFORMANT'S NAME (Type/Print): FRANK METZLER, JR.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 508 GLEN VIEW AVE. GLEN BURNIE, MD 21061	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK 3-30-92	20c. LOCATION — City or Town, State: GLEN BURNIE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James J. Siebert		22. NAME AND ADDRESS OF FACILITY: SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory srrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIOPULMONARY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CHRONIC RENAL FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. OLD BRAIN INJURY	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D27838	29d. DATE SIGNED (Month, Day, Year): ▶ 3/24/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN S. STAVROS 518 CAMP MEADOW RD LINTHICUM 21090

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: [illegible]

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92 09047

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BARBARA LORRAINE MYERS			2. DATE OF DEATH (Month, Day, Year): 03 25 1992	3. TIME OF DEATH: 8:15 pm M
4. SOCIAL SECURITY NUMBER: 216-36-3305	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 03 09 1939	8. BIRTHPLACE (State or Foreign Country): WASHINGTON DC
9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY OF MARYLAND HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: GLEN BURNIE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7579 BALTIMORE ANNAPOLIS BLVD.		10f. ZIP CODE: 21060	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): NONE	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ADMINISTRATIVE SECRETARY	16b. KIND OF BUSINESS/INDUSTRY: MARYLAND GENERAL HOSPITAL	
17. FATHER'S NAME (First, Middle, Last): KAYLE ECKLEY		18. MOTHER'S NAME (First, Middle, Maiden Surname): GLADYS HYMILLER	
19a. INFORMANT'S NAME (Type/Print): DONALD H. MYERS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7579 BALTIMORE ANNAPOLIS BLVD. GLEN BURNIE, MD 21060	

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL PARK	DATE: 3-30	20c. LOCATION — City or Town, State: ELKRIDGE MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jamie J. Siebert		22. NAME AND ADDRESS OF FACILITY: SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Coronary Artery Disease — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. — DUE TO (OR AS A CONSEQUENCE OF):	
	c. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of Carotid Stenosis
History of Cerebral Aneurysm
Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28c. DATE OF INJURY (Month, Day, Year): 3/25/92	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 3/26/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): W.L. Tyson Dept of Cardiothoracic Surgery UMH

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

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DHMH-16 Rev 1/89

92 09048

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Georgetta Scott Morrison
2. DATE OF DEATH: MONTH March DAY 31, YEAR 1992
3. TIME OF DEATH: 8:20 A M
4. SOCIAL SECURITY NUMBER: 373-26-5373
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 89 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/10/02
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Fairhaven Health Center
9b. CITY, TOWN OR LOCATION OF DEATH: Sykesville
9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Towson
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8211 Burnley Road
10f. ZIP CODE: 21204
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementery/Secondary (0-12); College (1-4 or 5+): 1
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): James Scott
18. MOTHER'S NAME (First, Middle, Maiden Surname): Viola Victor
19a. INFORMANT'S NAME (Type/Print): Ann M. Angle
19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8211 Burnley Road Towson, MD 21204
20a. METNOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc. DATE 4/1
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb
22. NAME AND ADDRESS OF FACILITY: Cremation Society of Md., Inc. 299 Frederick Road Balto., MD 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on aach line. — Approximate Interval Batween Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebrovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
OUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. OESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Ellis Mez MD
29c. LICENSE NUMBER: D22220
29d. DATE SIGNED (Month, Day, Year): March 31, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ellis Mez, M.D. 1645 Liberty Road Sykesville, MD 21784
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Jisha Davidson-Kondelka

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR Thomas E. Mowbray

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09049 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THOMAS E. MOWBRAY
2. DATE OF DEATH: MONTH 3 DAY 23 YEAR 92
3. TIME OF DEATH: 11:50A M
4. SOCIAL SECURITY NUMBER: 165-12-2487
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 86 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): March 28, 1905
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: -------n/a------

RESIDENCE OF DECEDENT

10a. STATE: PA
10b. COUNTY: -------n/a-------
10c. CITY, TOWN OR LOCATION: Philadelphia
10d. INSIDE CITY LIMITS? XX YES 2 ☐ NO
10e. STREET AND NUMBER: 5014 Valley Street
10f. ZIP CODE: 19124
10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW I
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES XX NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 years — College (1-4 or 5+): ----------
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Iron Worker
16b. KIND OF BUSINESS/INDUSTRY: Iron Industry
17. FATHER'S NAME (First, Middle, Last): Thomas E. Mowbray
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary E. Wilkenson
19a. INFORMANT'S NAME (Type/Print): Joanne Patry
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1822 Deveron Drive Balto., MD 21234
20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill — DATE: 3/26
20c. LOCATION — City or Town, State: Philadelphia, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Cori L. Ebaugh
22. NAME AND ADDRESS OF FACILITY: Johnson Funeral Home Balto., MD 8521 Loch Raven Blvd. 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Rt Intra Cereleral Hematoma
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ~~Bilateral Pneumonias~~ known
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Respiratory failure and bilateral Pneumonia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Gurusamy Staff Surgeon
29c. LICENSE NUMBER: D17005
29d. DATE SIGNED (Month, Day, Year): ▶ 3/23/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): G S H. DR. GOPAL GURUSAMY, Surgery Department
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

92 09050

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM C. METZGER
2. DATE OF DEATH (Month, Day, Year): MARCH 26, 1992
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 219-32-9437
5. SEX: XX 1 M 2 F
6. AGE (In yrs. last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-19-1928
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: DUNDALK
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO
10e. STREET AND NUMBER: 7720 NORBUSH AVENUE
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12TH GRADE — College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRODUCE - SELF EMPLOYED
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): WILLIAM C. METZGER, SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY A. BRENDLE
19a. INFORMANT'S NAME (Type/Print): EMMA L. METZGER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7720 NORBUSH AVENUE BALTIMORE, MARYLAND 21222
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): SACRED HEART OF JESUS CEM. — DATE: 3/30
20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL/SERVICE LICENSEE: ▶ Charles W. Fisher
22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myo cardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Wally MD
29c. LICENSE NUMBER: D26735
29d. DATE SIGNED (Month, Day, Year): ▶ 3/26/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): MAR 30 1992
32. REGISTRAR'S SIGNATURE: Judith Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 29 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92-1681-005

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09051 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DAWAIN M. NEAL
2. DATE OF DEATH (Month, Day, Year): 03 22 92
3. TIME OF DEATH: 2:26 A M
4. SOCIAL SECURITY NUMBER: 218-86-7207
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 20 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-5-1972
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GENERAL
9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10e. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10a. STREET AND NUMBER: 700 Augusta Avenue
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY? U S A
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Donald Johnson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Caroline Neal
19a. INFORMANT'S NAME (Type/Print): Caroline Neal
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 700 Augusta Avenue Baltimore, Md 21229
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial Park DATE: 32792
20c. LOCATION — City or Town, State: Randallstown, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale March
22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Avenue

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Asthma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): 03/22/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK J. PERETTI 111 PENN STREET, BALTIMORE, MARYLAND 21201
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09052

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)			3. TIME OF DEATH
Beulah	Zade	Ohle	03	30	92	3 p. m.

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
220-44-9853	1 ☐ M 2 ☒ F	97 YRS.			08-27-1894	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Presbyterian Home of Maryland	Towson	Baltimore County

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Baltimore County	Rodgers Forge	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
422 Murdock Road	21212	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5 +)		
12 yrs.		Typist/Clerk	Insurance

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Philip Ohle	Delilah C Wisler

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Presbyterian Home of Maryland	400 Georgia Court, Towson, Maryland 21204

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Parkwood Cemetery	04-03-92	Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ John G. Reitz John G. Reitz	Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIO PULMONARY ARREST	Min
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF):	Days
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GENERALIZED ARTERIOSCLEROSIS
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Retirement Home

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
S. J. Venable, M.D.	D11026	▶ March 31, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

S. J. VENABLE, M.D., 610 WILTON ROAD TOWSON, MD 21204

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 31 1992	Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09053

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES J. PASELA
2. DATE OF DEATH: MONTH 03 DAY 26, YEAR 1992
3. TIME OF DEATH: 11: 20 a M
4. SOCIAL SECURITY NUMBER: 216-09-5996
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 88 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 03-07-1904
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): G.B.M.C.
9b. CITY, TOWN OR LOCATION OF DEATH: 6701 N. Charles Street
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 9603 Brookbend Road
10f. ZIP CODE: 21236
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA; College (1-4 or 5+): NA
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF-EMPLOYED
16b. KIND OF BUSINESS/INDUSTRY: RETAIL SALES
17. FATHER'S NAME (First, Middle, Last): JACOB PASELA
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY ANNA OLEISKI
19a. INFORMANT'S NAME (Type/Print): M. ALICE PASELA (WIFE)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9603 BROOKBEND RD., BALTIMORE, MD 21236
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): DULANEY VALLEY MEM'L GARDENS — DATE
20c. LOCATION — City or Town, State: TIMONIUM, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOMES, INC. 9705 BELAIR ROAD, BALTIMORE, MD 21236

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. RESPIRATORY ARREST
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ASPIRATION & PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF):
c. ASPIRATION 2ND TO VOMITING
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature], MD
29c. LICENSE NUMBER: D37016
29d. DATE SIGNED (Month, Day, Year): ▶ 3/26/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kenneth M. Greene, MD 3334 Paper Mill Road, Phoenix, MD 21131
31. DATE FILED (Month, Day, Year): MAR 3 1 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09054
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jacob. V. Popp / Jacob Vernon Popp				2. DATE OF DEATH: MONTH 3 DAY 29 YEAR 92	3. TIME OF DEATH: 10:10 P M
4. SOCIAL SECURITY NUMBER: 220-01-4476	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5-4-21	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Fallston		9c. COUNTY OF DEATH: Harford	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Harford	Edgewood	1 ☐ YES 2 XX NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
818 Clover Leaf Ct.	21040	U. S. A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	XX YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII	1 ☐ YES 2 XX NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
NA	NA	Route Salesman	Milk Company

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Robert Popp	Sadie Bunch

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy M. Popp (Wife)	818 Clover Leaf Ct., Edgewood, Md. 21040

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Louden Park Cemetery	Baltimore, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ John F. Collins	Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary Artery Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Metastatic Prostate CA.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 X NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 X NO	HOSPITAL: X 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Steven Bentman MD	D 36487	▶ 3/30/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEVEN BENTMAN MD 8817 Belair Rd Baltimore MD 21236

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 31 1992	Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09055

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CATHERINE E. RAYMOND			2. DATE OF DEATH (Month, Day, Year): MARCH 26 1992	3. TIME OF DEATH: 6:24 A M
4. SOCIAL SECURITY NUMBER: 212-07-8674	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JULY 23,1914	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): GOOD SAMARITAN HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH: ---	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4716 BEACONSFIELD DRIVE		10f. ZIP CODE: 21236	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA; College (1-4 or 5+): NA	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FACTORY WORKER	16b. KIND OF BUSINESS/INDUSTRY: MANUFACTURING COMPANY	
17. FATHER'S NAME (First, Middle, Last): NORMAN POPER		18. MOTHER'S NAME (First, Middle, Maiden Surname): BERTHA RAHL	
19a. INFORMANT'S NAME (Type/Print): JO ANN T. CAVALLUCCI (DGHTR)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4716 BEACONSFIELD DR., BALTIMORE, MD 21236	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MOST HOLY REDEEMER CEMETERY	DATE	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John F. Schimunek		22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOMES, INC. 9705 BELAIR RD., BALTIMORE, MD 21236	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. COPD	
	OUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CO2 narcosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHF
IDDM

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. Ansari MD	29c. LICENSE NUMBER: P64-7	29d. DATE SIGNED (Month, Day, Year): ▶ 3/26/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. ANSARI 5601 Loch Raven Blvd., Baltimore, MD 21239		
31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Julie Davidson-Kennedy	

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09056

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mabel E. Romagnoli
2. DATE OF DEATH (Month, Day, Year): 03 28 92
3. TIME OF DEATH: 8:42A M
4. SOCIAL SECURITY NUMBER: 213-12-0628
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 28, 1905
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: - - - -

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: - - - -
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8742 Oakleigh Road
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA — College (1-4 or 5+): NA
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Charles H. Hesse
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosie E. Salisbury
19a. INFORMANT'S NAME (Type/Print): Eleanor Remeikis (Dghtr)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8742 Oakleigh Road, Baltimore, Md. 21234
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery — DATE:
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm H Hesse Jr
22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	VENTRICULAR TACHYCARDIA	MINUTES
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	SEVERE CAD	MONTHS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
(L) CVA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: FRED TACKEY MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SOD SAMARITAN HOSPITAL 5601 LOCH R
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Davidson-Randall

DHMH-16 Rev 1/89

4

92-1804-510

92 09057

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The information required on this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 29 is any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
MILOS	BORISLAV	RADWICK	03 28 1992	8:42 p M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
212-56-6443	1 [X] M 2 [ ] F	64 YRS.			9-28-27	YUGOSLAVIA

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
HARBOR HOSPITAL CENTER	BALTIMORE	N/A ----------

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	ANNE ARUNDEL	SEVERNA PARK	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
646 EMERSON PLACE	21146	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12	12	PHYSICIAN	ORTHAPEDIC SURGEON

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
BORISLAV RADWICK	DANICA SIMOVIC

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
YVETTE S. RADWICK	LES TERRASSES DU LEVANT, 24 CHEMIN DE VESSY, FERNEY-VOLTAIRE ------ FRANCE 01210

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	METRO CREMATORY INC.	4-2-92	BALTIMORE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ R. Heyse Hopkins	SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
A M DIXON	O.C.M.E.	▶ 03/29/1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
A M DIXON	111 PENN STREET BALTIMORE, MARYLAND 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 31 1992	[signature]

DHMH-16 Rev 1/89

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92 09058

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Kenyon Rauser, Sr. / CHARLES RAUSER SR
2. DATE OF DEATH (Month, Day, Year): 03/28/92 / 3 28 92
3. TIME OF DEATH: 11 AM
4. SOCIAL SECURITY NUMBER: 220-09-5003
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 73 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 07/13/18
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 608 Pamela Road 21061
9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie
9c. COUNTY OF OEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD / MD
10b. COUNTY: Anne Arundel / A.A.
10c. CITY, TOWN OR LOCATION: Glen Burnie / GLEN BURNIE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 608 Pamela Road / 608 PAMELA Rd
10f. ZIP CODE: 21061 / 21061
10g. CITIZEN OF WHAT COUNTRY? USA / USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Technical Associate
16b. KIND OF BUSINESS/INDUSTRY: Westinghouse Electric
17. FATHER'S NAME (First, Middle, Last): Paul Martin Rauser, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Harvey Starkey
19a. INFORMANT'S NAME (Type/Print): Margareta M. Rauser
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 Pamela Road Glen Burnie, MD 21061
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc. DATE: 3/30
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb
22. NAME AND ADDRESS OF FACILITY: Cremation Society of Md., Inc. 299 Frederick Road Balto., MD 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CANCER OF THE LIVER — Approximate Interval Between Onset and Death: 6 mo.
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D00034-P
29d. DATE SIGNED (Month, Day, Year): 3/28/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SERGIO ALVAREZ MD 1720 CRAIN HIGHWAY S. GB
31. DATE FILED (Month, Day, Year): MAR 3 1 1992
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

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92 09059

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Agnes Revnoc				2. DATE OF DEATH: MONTH 03 DAY 24 YEAR 1992	3. TIME OF DEATH: 9:30 P. M
4. SOCIAL SECURITY NUMBER: 175 18 8412	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7/3/1918	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 8258 Minton Court			9b. CITY, TOWN OR LOCATION OF DEATH: Millersville		9c. COUNTY OF DEATH: Anne Arundel
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: ========	10c. CITY, TOWN OR LOCATION: Baltimore			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3612 St. Margaret Street		10f. ZIP CODE: 21225		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home Maker			
17. FATHER'S NAME (First, Middle, Last): Joseph Bistransky		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Horvat			
19a. INFORMANT'S NAME (Type/Print): Evelyn Benik	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 974 Waterview Drive Crownsville, Maryland 21032				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park	DATE: 3-27	20c. LOCATION — City or Town, State: Glen Burnie, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard E. Davis	22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet caused tha death. Do not anter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liat only one ceuae on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in daeth) →	a. Metastatic Non-Small Cell Lung Cancer	1.1 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly liat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST	b. Chronic Bronchitis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Emphysema	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Chronic Cigarette Use	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.: Malnutrition 2° # A.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dean M. Swinford	29c. LICENSE NUMBER: D-22575	29d. DATE SIGNED (Month, Day, Year): 3/25/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09060

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Corrine Jeannette ROYSTER
2. DATE OF DEATH: MONTH 03 DAY 27 YEAR 92
3. TIME OF DEATH: 03:20 AM M
4. SOCIAL SECURITY NUMBER: 277-26-4529
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 03-26-1930
8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL ASSOCIATION
9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE
9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Glen Burnie
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7900 Benesch Circle Apt. # 831
10f. ZIP CODE: 21061
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th Grade — College (1-4 or 5+): 2+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fed. Res. Bank Richmond
16b. KIND OF BUSINESS/INDUSTRY: Banker
17. FATHER'S NAME (First, Middle, Last): Almon Perry Rose
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sada Mae Combs
19a. INFORMANT'S NAME (Type/Print): Gloria Fogle
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1845 Choptank Rd., Pasadena, Md. 21122
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc. — DATE: 3-28-92
20c. LOCATION — City or Town, State: Catonsville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F. Hackman Jr.
22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home, 3204 Mountain Rd., Pasadena, Md. 21122

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Emphysema
DUE TO (OR AS A CONSEQUENCE OF):
b. Acute Overdose
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Approximate Interval Between Onset and Death: Days

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D20094
29d. DATE SIGNED (Month, Day, Year): ▶ 3/27/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ELLIOTT GORBATY, M.D./7845 OAKWOOD RD. #203/GLEN BURNIE, MARYLAND 21061
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

10

92 09061

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Rawls, Hattie HATTIE RAWLS			2. DATE OF DEATH (Month, Day, Year) 3-24-92	3. TIME OF DEATH 19:32 M
4. SOCIAL SECURITY NUMBER	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 96 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 2-2-1896	8. BIRTHPLACE (State or Foreign Country) Alabama
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	9c. COUNTY OF DEATH na		

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY na	10c. CITY, TOWN OR LOCATION Baltimore	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER 2204 N. Calvert Street		10f. ZIP CODE 21218	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)		
19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 3.30.92	22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD 655 W. Baltimore St, Balto., MD 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CRF	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Metabolic Acidosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Respiratory Failure	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER MD	29c. LICENSE NUMBER House Staff	29d. DATE SIGNED (Month, Day, Year) ▶ 3/24/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gonzalo Gonnlen 201 E. Univ Pkwy Balt. MD

31. DATE FILED (Month, Day, Year) MAR 30 1992	32. REGISTRAR'S SIGNATURE Gina Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09062

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Scott, BG BABY MONET E.M. GARRISON SCOTT
2. DATE OF DEATH: MONTH 3 DAY 27 YEAR 92
3. TIME OF DEATH: 505 P M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☐ F
6. AGE (In yrs. last birthday): IF UNDER 1 YEAR: MONTHS: DAYS 7; IF UNDER 24 HRS.: HOURS: MIN.:
7. DATE OF BIRTH (Month, Day, Year): 3/20/92
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Univ of Md Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Balt Md
9c. COUNTY OF DEATH: Balt

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 727 GEORGE STREET
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): CHILD; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CHILD
16b. KIND OF BUSINESS/INDUSTRY: CHILD
17. FATHER'S NAME (First, Middle, Last): MAURICE GARRISON
18. MOTHER'S NAME (First, Middle, Maiden Surname): DEONNA SCOTT
19a. INFORMANT'S NAME (Type/Print): JOYCE SCOTT
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 727 GEORGE STREET/BALTIMORE, MD 21201
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): KING MEMORIAL PARK — DATE:
20c. LOCATION — City or Town, State: RANDALLSTOWN, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard Hall
22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypoplastic Left Heart DUE TO (OR AS A CONSEQUENCE OF):	7d
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: J Brenner MD
29c. LICENSE NUMBER: D 17850
29d. DATE SIGNED (Month, Day, Year): ▶ 3/27/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 225 Greene St Baltimore md 21201
31. DATE FILED (Month, Day, Year): MAR 3 1 1992
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH-18 Rev 1/89

92 09063

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles J. Schick (Charles J. Schick)
2. DATE OF DEATH (Month, Day, Year): 3 / 29 / 92
3. TIME OF DEATH: 9:50 PM
4. SOCIAL SECURITY NUMBER: 214-01-5325
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct. 25, 1911
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Mercy Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: - - - -

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: - - - -
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 124 W Franklin St.
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY?: US
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [XX] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White.
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA — College (1-4 or 5+): NA
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cabinet Maker
16b. KIND OF BUSINESS/INDUSTRY: Self-Employed
17. FATHER'S NAME (First, Middle, Last): John Schick
18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Ries
19a. INFORMANT'S NAME (Type/Print): Michael Gossman (Nephew)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7785 Nutley Rd., Pasadena, Md. 21122
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Oaklawn Cemetery — DATE:
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm D Schick
22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Intracranial ~~Bleed~~ hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Gram Negative Septicemia
DUE TO (OR AS A CONSEQUENCE OF):
c. adenocarcinoma of prostate
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: R Thomas MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 3/29/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mercy Medical Center
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE:

DHMH-18 Rev 1/89

92 09064

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2-3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MILTON H. STEPHENS			2. DATE OF DEATH (Month, Day, Year): MARCH 29, 1992	3. TIME OF DEATH: 8:00 PM
4. SOCIAL SECURITY NUMBER: 216-44-3866	5. SEX: XX 1 M 2 F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 10, 1924	8. BIRTHPLACE (State or Foreign Country): WASHINGTON, D.C.
9a. FACILITY NAME (If not institution, give street and number): MERCY HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: --
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: --	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? XX 1 YES 2 NO
10e. STREET AND NUMBER: 806 GLEN ALLEN DRIVE		10f. ZIP CODE: 21229		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 Never Married XX 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES XX 2 NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES XX NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+): 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ACCOUNTANT		16b. KIND OF BUSINESS/INDUSTRY: I.R.S.
17. FATHER'S NAME (First, Middle, Last): MILTON STEPHENS			18. MOTHER'S NAME (First, Middle, Maiden Surname): LOUISE WIDMAYER	
19a. INFORMANT'S NAME (Type/Print): FRANCES P. STEPHENS (WIFE)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 806 GLEN ALLEN DRIVE, BALTIMORE, MARYLAND 21229		
20a. METHOD OF DISPOSITION: XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): LOUDON PARK CEMETERY DATE: 4/1/92		20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lenora Witzke Lewis		22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

c. aspiration

DUE TO (OR AS A CONSEQUENCE OF):

d. cerebral vascular accident

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: seizure disorder

24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 8 Other (Specify)	
27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 YES 2 NO; 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C Schoedel MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): 3/29/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C SCHOEDEL 301 St Paul Pl Balt. 21202

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson Rodwell

DHMH-16 Rev 1/89

92 09065

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLARA A. STINER / Clara A. Stiner			2. DATE OF DEATH (Month, Day, Year): March 30, 1992	3. TIME OF DEATH: 3:00 AM
4. SOCIAL SECURITY NUMBER: 212-46-9957	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 10, 1914	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Hamilton Nsg. Home		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3415 Mt. Pleasant Ave.		10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yr's; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Travis T. Luke, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Klein	
19a. INFORMANT'S NAME (Type/Print): Mr. Allen L. Davis		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4000 Marx Ave. Baltimore, MD 21206	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Lorraine Park; DATE: 4/1/92	20c. LOCATION — City or Town, State: Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock, Jr. / ▶ Paul L. Hartsock, Jr.		22. NAME AND ADDRESS OF FACILITY: Baltimore, MD 21214 / Leonard J. Ruck, Inc. 5305 Harford Rd.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Probable Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Insulin Dependent DM
Renal Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margaret Soares MD	29c. LICENSE NUMBER: D16619	29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 2947 St. Paul St. BALT. MD. 21218 C. VERGARA-SOARES

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09066
REG. NO.

DIVISION OF VITAL RECORDS, BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the medical certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JESSIE SIMMS
2. DATE OF DEATH: MONTH 3 DAY 29 YEAR 92
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 243-64-0540
5. SEX: 1 ☐ M 2 ☐ F
6. AGE (In yrs. last birthday): 51 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-10-40
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): 851 GEORGE ST APT. 3F
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 851 GEORGE ST.
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECURITY GUARD
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Robert SIMMS
18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Phillips
19a. INFORMANT'S NAME (Type/Print): Hattie Hughes
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 332 S. FRANKLINTOWN Rd. Balto. Md. 21223
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): DATE
20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm C. Brown
22. NAME AND ADDRESS OF FACILITY: WM. C. BROWN COMMUNITY F/H 1206 W. NORTH AVE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. MASSIVE PLEURAL EFFUSION WITH CONGESTED LUNG
DUE TO (OR AS A CONSEQUENCE OF):
b. LUNG CANCER

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
BRONCHITIS | PNEUMONIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: MD39771
29d. DATE SIGNED (Month, Day, Year): ▶ 03-30-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID WHEELOR, MD BOX 243 22 SOUTH GREENE ST BALTIMORE 21201
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Ramsey

DHMH-16 Rev 1/89

92 09067

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edith L. Schott / EDITH L SCHOTT			2. DATE OF DEATH (Month, Day, Year): 03/29/92 (3 29 92)	3. TIME OF DEATH: 410 P M
4. SOCIAL SECURITY NUMBER: 214-74-2557	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 05/19/00	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): ST AGNES HOSP		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: ---

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Catonsville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 18 Sanford Avenue		10f. ZIP CODE: 21228	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Wilson Nicholas Lynch		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lida England	
19a. INFORMANT'S NAME (Type/Print): Carol D. Palmer	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18 Sanford Avenue Catonsville, MD 21228		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery	DATE: 4/2	20c. LOCATION — City or Town, State: Woodlawn, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb	22. NAME AND ADDRESS OF FACILITY: MacNabb Funeral Home, P.A. 301 Frederick Road Balto., MD 21228		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CHF
DUE TO (OR AS A CONSEQUENCE OF):
b. ATRIAL Fibrillation
DUE TO (OR AS A CONSEQUENCE OF):
c. CARDIOMYOPATHY
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
New onset seizures
BILATERAL PLEURAL EFFUSION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature], MD	29c. LICENSE NUMBER: RESIDENT	29d. DATE SIGNED (Month, Day, Year): 3/29/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MUTOMBO KANKONDE, ST AGNES HOSP BALTIMORE MD		
31. DATE FILED (Month, Day, Year): MAR 3 1 1992	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

15

92 09068

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Pearl M. Schaeffer / Pearl S Schaeffer			2. DATE OF DEATH MONTH 03 DAY 25 YEAR 92	3. TIME OF DEATH 0110 A M	
4. SOCIAL SECURITY NUMBER 218 01 6815	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 2/28/1911	8. BIRTHPLACE (State or Foreign Country) Ohio
9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Balt. City	9c. COUNTY OF DEATH ==========	
RESIDENCE OF DECEDENT:					
10a. STATE MD	10b. COUNTY ========	10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER 1190 W. Northern Parkway		10f. ZIP CODE 21210		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife	16b. KIND OF BUSINESS/INDUSTRY Home Maker			
17. FATHER'S NAME (First, Middle, Last) Collins	18. MOTHER'S NAME (First, Middle, Maiden Surname)				
19a. INFORMANT'S NAME (Type/Print) Joan Secoura	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5201 Disney Avenue Baltimore, Maryland 21225				
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery	DATE 3-27	20c. LOCATION — City or Town, State Baltimore, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donna M Bramerowski	22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF):	1 HOUR
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		1 ☐ YES 2 ☐ NO	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D22545	▶ 3-26-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 31 1992	Gina Davidson-Randall

DHMH-16 Rev 1/89

92 09069

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES Lee Shipley / James L. Shipley			2. DATE OF DEATH: MONTH March DAY 29 YEAR 1992	3. TIME OF DEATH: 1045 PM
4. SOCIAL SECURITY NUMBER: 214 90 9119	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 28 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2/26/1964
8. BIRTHPLACE (State or Foreign Country): Maryland				
9a. FACILITY NAME (If not institution, give street and number): 2827 Tennessee Avenue		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore county

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore County	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2827 Tennessee Avenue		10f. ZIP CODE: 21227	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sheet Metal Worker	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): James B. Shipley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret E. Lovelle	
19a. INFORMANT'S NAME (Type/Print): Margaret Shipley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2827 Tennessee Avenue Baltimore, Maryland 21227	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.	DATE: 3-31	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Richard Gonce	22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gunshot wound of Head — DUE TO (OR AS A CONSEQUENCE OF):	Immediate
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Depression — DUE TO (OR AS A CONSEQUENCE OF):	
	c. Drug addiction — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): March 29, 1992	28b. TIME OF INJURY: 1040 PM	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
	28d. DESCRIBE HOW INJURY OCCURED: Shot Self		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Trailer		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2827 Tennessee Ave

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Deputy Medical Examiner	29c. LICENSE NUMBER: D01085	29d. DATE SIGNED (Month, Day, Year): ▶ March 29, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Stat 2. Fellenbaum MD 1 E. Chase St 3120		
31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall	

OHMH-16 Rev 1/89

92 09070

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John H STANBAUGH. (JOHN HARRY STAMBAUGH)
2. DATE OF DEATH (Month, Day, Year): 3 29 92
3. TIME OF DEATH: 6:15 AM
4. SOCIAL SECURITY NUMBER: 217-01-3179
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Jan. 28, 1912
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. JOSEPH Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 124 W. Franklin St.
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teller
16b. KIND OF BUSINESS/INDUSTRY: Bank
17. FATHER'S NAME (First, Middle, Last): Harry Resdon Stambaugh
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mayme O'Brien
19a. INFORMANT'S NAME (Type/Print): John B. Wilhelm, Sr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 307 Deepdale Drive, Timonium, Md. 21093
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery — DATE: 4/1/92
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F. Burnside, Jr. / James F. Burnside, Jr.
22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Aspiration Pneumonia	15 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Swallowing Malfunction	6 mos.
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Tracheostomy with Mucus Plugs
COPD
Hyperparathyroidism

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ~~X~~ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ~~X~~ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ~~X~~ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard D. Patterson MD
29c. LICENSE NUMBER: D39609
29d. DATE SIGNED (Month, Day, Year): 3/29/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard D. Patterson Sr Joseph's Hospital 7620 York Road Baltimore MD 21204
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Julia Brinkman-Hendricks

DHMH-16 Rev 1/89

Film #686, Item 6, 7, 19a, 4/28/92, P.T.

92 09071

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ASHTON SCHIAFFINO		2. DATE OF DEATH (Month, Day, Year): March 27, 1992	3. TIME OF DEATH: 4:00 pM
4. SOCIAL SECURITY NUMBER: 212-01-0108	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): ~~78~~ 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 09/25/~~1913~~ 1911
8. BIRTHPLACE (State or Foreign Country): Baltimore, MD			
9a. FACILITY NAME (If not institution, give street and number): 8 Brooking Court unit 202	9b. CITY, TOWN OR LOCATION OF DEATH: Timonium	9c. COUNTY OF DEATH: Baltimore	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Timonium	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 8 Brooking Court unit 202	10f. ZIP CODE: 21093	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Statistician	16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel	
17. FATHER'S NAME (First, Middle, Last): Fortunato Schiaffino	18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Gamble		
19a. INFORMANT'S NAME (Type/Print): Mary ~~Burk~~ Evans Schiaffino	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Brooking Court unit 202 Timonuim, MD 21093		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Paul's Lutheran Ch. Cem. DATE: 3/30	20c. LOCATION — City or Town, State: Arcadia, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas Joseph Bozek	22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home Inc. 6500 York Road Baltimore, Maryland 21212		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Prostate Carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal Failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Francis L. Wiegmann Jr. MD.	025569	3/29/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Francis Wiegmann MD 8406 Harford Rd. / Baltimore, Md. 21234

31. DATE FILED (Month, Day, Year)	REGISTRAR'S SIGNATURE
MAR 31 1992	

3

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Florence E. Stewart			2. DATE OF DEATH (Month, Day, Year): March 27, 1992	3. TIME OF DEATH: 9:30 A. M
4. SOCIAL SECURITY NUMBER: 218-05-1022	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 12/13/14	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 3202 Acton Road		9b. CITY, TOWN OR LOCATION OF DEATH: Parkville		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Parkville		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3202 Acton Rd.		10f. ZIP CODE: 21234		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yr's; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clothing Work		16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Henry Stewart			18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Berger	
19a. INFORMANT'S NAME (Type/Print): Mr. Robert M. Stewart		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cem. DATE: 3/30/92		20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Paul L Hartsock Jr. Paul L. Hartsock, Jr.		22. NAME AND ADDRESS OF FACILITY: Baltimore, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Colonic Carcinoma c Metastasis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Colonic obstruction 2° to Colonic ca	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Anemia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	26d. DESCRIBE HOW INJURY OCCURED		
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D27670	▶ 3/27/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph C. Lin 8903 Harford Road Baltimore, Md. 21234

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 30 1992	Linda Davidson-Randall

DHMH-16 Rev 1/89

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92-1732-510

92 09073

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THELMA L. SCHREINER
2. DATE OF DEATH (Month, Day, Year): 03 24 1992
3. TIME OF DEATH: 9:50 A.M
4. SOCIAL SECURITY NUMBER: 216-20-0550
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/25/1906
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1808 BYRD STREET
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: --------

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: --------
10c. CITY, TOWN OR LOCATION: Balto.City,Md.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1808 Byrd St.
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th.Grade — College (1-4 or 5+): ------
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Roland ---- Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sophia ----- Ficasic
19a. INFORMANT'S NAME (Type/Print): Mrs.Yvonne M.Barcroft
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1834 Byrd St. Balto.Md. 21230
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery — DATE: 3/27
20c. LOCATION — City or Town, State: A.A.Co.Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul A Hayes
22. NAME AND ADDRESS OF FACILITY: Balto.Md.21230 McCully Funeral Home,130 E.Fort Ave

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. MULTIPLE INJURIES
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golve Jr. MD
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): 03-25-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARIO F. GOLVE JR, MD 111 PENN STREET BALTIMORE MARYLAND 21201
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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Item28f 4-20-92 FilmG686 W.H. Per Ocme
Item 28f, per MEO, G-687, 5/1/92 gn

92-1710-003

Items: 23 part I,27,28a, ,c,d,e,f per MEO

92 09074

1 - FOR STATE REGISTRAR G-686 4/7/92 reb

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHRISTOPHER SLOMSKI JR.				2. DATE OF DEATH (Month, Day, Year): 03 22 1992	3. TIME OF DEATH: 7:33 P.M
4. SOCIAL SECURITY NUMBER: 220 25 6426	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 4 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): August 3,1987	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE	9c. COUNTY OF DEATH: ANNE ARUNDEL
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Pasadena			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7958 Cobbler Ln.		10f. ZIP CODE: 21122		10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0	College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A		16b. KIND OF BUSINESS/INDUSTRY: N/A	
17. FATHER'S NAME (First, Middle, Last): Christopher Slomski, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Carol A. Rosso			
19a. INFORMANT'S NAME (Type/Print): Christopher Slomski, Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7958 Cobbler Ln., Pasadena, MD 21122			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Cedar Hill Cemetery DATE: 3/26/92		20c. LOCATION — City or Town, State: Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stephen D Plummer		22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hemopericardium
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Rupture of Left Ventricular Aneurysm
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 3/22/92
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: Subject had weight fall on chest
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 7958 Cobbler lane Pasadena, Anne Arundel County, MD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis J Chute MD
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): 03-23-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09075

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sophia Talley
2. DATE OF DEATH (Month, Day, Year): 3- 26-92
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 219-28-0177
5. SEX: 1 ☐ M 2 XX F
6. AGE (In yrs. last birthday): 57 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-27-35
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 5608 Denwood Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore, City
10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 5608 Denwood Avenue
10f. ZIP CODE: 21206
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementery/Secondery (0-12): 12th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AIDE
16b. KIND OF BUSINESS/INDUSTRY: ROSEWOOD STATE HOSPITAL
17. FATHER'S NAME (First, Middle, Last): CLARENCE SMITH
18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH LYONS
19a. INFORMANT'S NAME (Type/Print): LYNETTE TALLEY-DUNN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5781 CEDONIA AVE. APT. C/BALTIMORE, MD 21206
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): KING MEMORIAL PARK — DATE:
20c. LOCATION — City or Town, State: RANDALLSTOWN, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Wm.C. March F/H 1101 E. North Ave.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colon cancer — DUE TO (OR AS A CONSEQUENCE OF): — 6yrs 10mos.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D23675
29d. DATE SIGNED (Month, Day, Year): ▶ 3.30.92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ross C. Donehower, MD Johns Hopkins Oncology Ct. Baltimore, MD 21205
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

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92 09076

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Donald Edward THERRES			2. DATE OF DEATH (Month, Day, Year): March 26, 1992	3. TIME OF DEATH: 2:05 A M
4. SOCIAL SECURITY NUMBER: 212-42-3681	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): DEC. 22, 1941	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 5 C LUDDY COURT		10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA; College (1-4 or 5+): NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PARTS COUNTER-PERSON	16b. KIND OF BUSINESS/INDUSTRY: STANDARD AUTO
17. FATHER'S NAME (First, Middle, Last): JOHN THERRES		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY MURPHY	
19a. INFORMANT'S NAME (Type/Print): MARY R. THERRES (WIFE)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 C LUDDY COURT, BALTIMORE, MARYLAND 21234	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): BEL AIR MEMORIAL GARDENS; DATE:	20c. LOCATION — City or Town, State: BEL AIR, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Collins		22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOMES, INC. 9705 BELAIR RD., BALTIMORE, MARYLAND21236	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebrovascular accident
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Presser MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): 3/26/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jefferey Presser, MD 9000 Franklin Square Dr. Baltimore, MD 21237

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

6

92 09077

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles William TAYLOR			2. DATE OF DEATH (Month, Day, Year): March 25, 1992	3. TIME OF DEATH: 9:03 A M
4. SOCIAL SECURITY NUMBER: 212 18 1110	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5/5/1915	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Avalon Home Inc.		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington Co
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Washington County	10c. CITY, TOWN OR LOCATION: Hagerstown		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: Avalon Nur Home Rt#8, Box 35		10f. ZIP CODE: 21740		10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Refinisher		16b. KIND OF BUSINESS/INDUSTRY: Furniture
17. FATHER'S NAME (First, Middle, Last): Edward Taylor		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Conrad		
19a. INFORMANT'S NAME (Type/Print): Edith Willison		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 403, Belleview FL 32620		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir. 3/30/92		22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD 655W.Baltimore St, Balto.,MD 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory Failure	few min
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Pneumonia	1 week
DUE TO (OR AS A CONSEQUENCE OF): c.	CHF	1 week
DUE TO (OR AS A CONSEQUENCE OF): d.	Ca Lung	2 yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Senile dementia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Vasant Datta MD	29c. LICENSE NUMBER: D18019	29d. DATE SIGNED (Month, Day, Year): ▶ 3.25.92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): VASANT DATTA, MD 33H MILL ST HAGERSTOWN, MD 21740

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09078
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH CARROLL TEANO

2. DATE OF DEATH (Month, Day, Year): March 25, 1992

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 212-09-9213

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 86 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): March 21, 1906

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): 1407 Providence Road

9b. CITY, TOWN OR LOCATION OF DEATH: Towson

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Towson

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 1407 Providence Road

10f. ZIP CODE: 21204

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 4

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager

16b. KIND OF BUSINESS/INDUSTRY: Credit Industry

17. FATHER'S NAME (First, Middle, Last): Sylvester Andrew Teano

18. MOTHER'S NAME (First, Middle, Maiden Surname): Honora Hart

19a. INFORMANT'S NAME (Type/Print): Harry W. League, Jr.

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9048 Queen Maria Court, Columbia, Md. 21045

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery — DATE: 3/28/92

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest L. Feist III

22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac Arrythmia — Immediate

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF): Valvular Heart Disease - Mitral Regurgitation
c. DUE TO (OR AS A CONSEQUENCE OF): and Hypertensive Cardiovascular Disease
d. DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D14989

29d. DATE SIGNED (Month, Day, Year): 3-26-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Veniedo Alidio, M.D. 6010 York Road Baltimore, Maryland

31. DATE FILED (Month, Day, Year): MAR 31 1992

32. REGISTRAR'S SIGNATURE: [signature]

OHMH-16 Rev 1/89

92 09079

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: When the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CORRINE TUCKER				2. DATE OF DEATH (Month / Day / Year): 3 / 28 / 92	3. TIME OF DEATH: 135 PM
4. SOCIAL SECURITY NUMBER: 247-57-9998	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9/8/07	8. BIRTHPLACE (State or Foreign Country): S.C
9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY OF MARYLAND HOSPITAL ER			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1102 DRUID HILL AVE		10f. ZIP CODE: 21201	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABLE	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): UNKNOWN		18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): Claudius Tucker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1102 Druid Hill Ave, Balto Md 21201	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON Forest Vet	DATE: 4/1/92	20c. LOCATION — City or Town, State: Owings Mill Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm C. Brown		22. NAME AND ADDRESS OF FACILITY: Wm C. Brown Community FH 1206 W. North Ave	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SUDDEN DEATH	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☒ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: JL Dinner MD	29c. LICENSE NUMBER: D40059	29d. DATE SIGNED (Month, Day, Year): ▶ 3/28/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THOMAS DINNER MD UNIV. OF MD HOSPITAL 22 S. GREENE ST BALTIMORE MD 21201

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

92 09080

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERTA TOWNES				2. DATE OF DEATH (Month, Day, Year): 03 - 29 - 92	3. TIME OF DEATH: 6.45 A M
4. SOCIAL SECURITY NUMBER: 219526703	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 44 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9/11/47	8. BIRTHPLACE (State or Foreign Country): Baltimore,
9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore md		9c. COUNTY OF DEATH: Balto City	

RESIDENCE OF DECEDENT

10a. STATE: md	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Balto.	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 2634 Quantico Ave.		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY: State office Building	
17. FATHER'S NAME (First, Middle, Last): Robert Hill		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ernestine Hopkins	
19a. INFORMANT'S NAME (Type/Print): Ernestine Hill	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2634 Quantico Ave. 21215		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery DATE: 4-3-92	20c. LOCATION — City or Town, State: Balto County	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale March	22. NAME AND ADDRESS OF FACILITY: March Funeral Home 4300 Wabash Ave		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. End Stage Metastatic breast Carcinoma. DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia, Electrolyte Imbalance.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jagdish P Mehta, M.D	29c. LICENSE NUMBER: D41410	29d. DATE SIGNED (Month, Day, Year): 3-29-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAGDISH P. MEHTA LIBERTY MEDICAL CENTER BALTIMORE MD

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE

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92-62

92 09081

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVANGELINE A. TURNER				2. DATE OF DEATH (Month, Day, Year): 03 26 1992	3. TIME OF DEATH: 2:15 P.M
4. SOCIAL SECURITY NUMBER: 233-56-9757	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 54 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): May 1, 1937	8. BIRTHPLACE (State or Foreign Country): W VA
9a. FACILITY NAME (If not institution, give street and number): LOCK RAVEN BRIDGE&MORGAN MILL RD.			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8300 Kendale Road		10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+): ----------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Technician	16b. KIND OF BUSINESS/INDUSTRY: Bendix Radio

17. FATHER'S NAME (First, Middle, Last): Arthur W. Turner	18. MOTHER'S NAME (First, Middle, Maiden Surname): Iris Hall
19a. INFORMANT'S NAME (Type/Print): David Turner	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12628 Grey Eagle Ct. # 42 Germantown, MD 20874

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Cemetery	DATE: 3/30	20c. LOCATION — City or Town, State: Timonium, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Cori L. Ebaugh	22. NAME AND ADDRESS OF FACILITY: Johnson Funeral Home, 8521 Loch Raven Blvd. Balto., MD 21204		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. DROWNING
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence ☒ Other (Specify) LOCK RAVEN BRIDGE	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 03-26-1992 28b. TIME OF INJURY: 11:30 A.M. 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: SUBJECT DROWNED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): RESERVOIR	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): LOCK RAVEN BRIDGE

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ 03-26-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HARRISON D. KOREN MD 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09082

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ollie Belle Warner					2. DATE OF DEATH (Month, Day, Year): March 29, 1992		3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 578 286813	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 03/10/1913		8. BIRTHPLACE (State or Foreign Country): Tennessee
9a. FACILITY NAME (If not institution, give street and number): Eastpoint Nursing Center					9b. CITY, TOWN OR LOCATION OF DEATH: Eastpoint		9c. COUNTY OF DEATH: Baltimore County
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Baltimore		10c. CITY, TOWN OR LOCATION: Essex				10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1630 Gail Road			10f. ZIP CODE: 21221				10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8	College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Home		
17. FATHER'S NAME (First, Middle, Last): (UNKNOWN)					18. MOTHER'S NAME (First, Middle, Maiden Surname): Addie Williams		
19a. INFORMANT'S NAME (Type/Print): Denise Creasy					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 56 "A1" Beech Drive Baltimore Maryland 21220		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Memorial Gardens	DATE: 4/1/92	20c. LOCATION — City or Town, State: Baltimore County, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]			22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home P.A. 1407 Eastern Ave Baltimore, MAryland 21221				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Heart Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1) Diabetes Mellitus
2) Chronic Obstructive Pulmonary Disease

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: 41150	29d. DATE SIGNED (Month, Day, Year): ▶ March 30, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 441 S. ELLWood AVE, BALTO, Md 21224

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

6

92 09083

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM E. WRIGHT JR.			2. DATE OF DEATH (Month, Day, Year): 03 28 92	3. TIME OF DEATH: 6:15 A M
4. SOCIAL SECURITY NUMBER: 410-64-0523	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 70 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 08/18/21	8. BIRTHPLACE (State or Foreign Country): TENNESSEE
9a. FACILITY NAME (If not institution, give street and number): 316 STONEWALL ROAD		9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE		9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: CATONSVILLE		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 316 STONEWALL ROAD		10f. ZIP CODE: 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 1942-1966	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2 YRS.	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): U.S. ARMY		16b. KIND OF BUSINESS/INDUSTRY: MILITARY
17. FATHER'S NAME (First, Middle, Last): WILLIAM E. WRIGHT		18. MOTHER'S NAME (First, Middle, Maiden Surname): RUTH MULLINS		
19a. INFORMANT'S NAME (Type/Print): LILLIAN WRIGHT (WIFE)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 316 STONEWALL ROAD CATONSVILLE, MD 21228		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON NATIONAL CEMETERY DATE 4/1/92		20c. LOCATION — City or Town, State: ARLINGTON, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Linda M. Witzke-Lewis		22. NAME AND ADDRESS OF FACILITY: LEROY M & RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE CATONSVILLE, MD 21228		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CANCER OF ESOPHAGUS DUE TO (OR AS A CONSEQUENCE OF):	1 YR
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BONE METASTASES
HYPERCALCEMIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD	D35606	3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAMUEL ZYGLER M.D. 4000 OLD COURT ROAD ROOM 306 BALTIMORE, MD 21208

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 31 1992	

DHMH-16 Rev 1/89

92-1809-510

Items: 23 part I,27,28a,b,c,d,e,f,per MEO G-686 4/1/92 reb

92 09084

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Cecelia Renee Williams			2. DATE OF DEATH: MONTH 3 DAY 29 YEAR 92	3. TIME OF DEATH: 4:53 A. M	
4. SOCIAL SECURITY NUMBER: 213-70-0112	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 33 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10-21-58	8. BIRTHPLACE (State or Foreign Country): MD.	
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City	9c. COUNTY OF DEATH		
RESIDENCE OF DECEDENT					
10a. STATE: MD.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO		
10e. STREET AND NUMBER: 827 Druid Park Lake Dr.		10f. ZIP CODE: 21217	10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: B		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic	16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last): Feaster Williams		18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Cooper			
19a. INFORMANT'S NAME (Type/Print): Frances Cooper Watkins		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 827 Druid Park Lake Dr Balto, MD. 21217			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park	DATE: 4-3-92	20c. LOCATION — City or Town, State: Balto. County, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm C. Brown		22. NAME AND ADDRESS OF FACILITY: 1206 W. North Ave William C. Brown Community F.H.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute alcohol intoxication	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 3/29/92	28b. TIME OF INJURY: A. M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: Subject ingested alcohol
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): private dwelling			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 727 Druid Park Dr. Baltimore City, Md.

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) end manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
A M DIXON	O.C.M.E.	▶ 3-29-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A M DIXON 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 31 1992	Julia Davidson-Ramsey

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL ORIGINATING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09085

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Earl Wesley Walker
2. DATE OF DEATH (Month, Day, Year): March 25 1992
3. TIME OF DEATH: 10:50 p.m. M
4. SOCIAL SECURITY NUMBER: 217-10-4314
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 29, 1911
8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Frostburg Village Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Rawlings
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Rt. 3, Box 105
10f. ZIP CODE: 21557
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): Unknown — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Filtration Dept.
16b. KIND OF BUSINESS/INDUSTRY: Textiles/Fibers Manufacture
17. FATHER'S NAME (First, Middle, Last): John Wesley Walker
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucretia Lewis
19a. INFORMANT'S NAME (Type/Print): John E. Walker
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 3, Box 43-A Rawlings, Maryland 21557
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Dawson Cemetery — DATE: 3/28/92
20c. LOCATION — City or Town, State: Dawson, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Brian F. Smith
22. NAME AND ADDRESS OF FACILITY: Rotruck Funeral Home 85 South Main Street Keyser, W.V. 26726

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetione that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardio-respiratory arrest	
DUE TO (OR AS A CONSEQUENCE OF):	C.A.D with angina.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: DO 8377
29d. DATE SIGNED (Month, Day, Year): 3-27-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Uriel E. Velandia, M.D. 924 Seton Drive Cumberland, Md. 21502
31. DATE FILED (Month, Day, Year): MAR 31 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09086
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Pauline Yates

2. DATE OF DEATH (Month, Day, Year): 03 29 1992

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 246 30 6694

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 68 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 9/19/1923

8. BIRTHPLACE (State or Foreign Country): North Carolina

9a. FACILITY NAME (If not institution, give street and number): 527 Pontiac Avenue

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH: ========

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Anne Arundel

10c. CITY, TOWN OR LOCATION: Glen Burnie

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 1304 Oakwood Road

10f. ZIP CODE: 21061

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 6th Grade
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Printer

16b. KIND OF BUSINESS/INDUSTRY: Box Factory

17. FATHER'S NAME (First, Middle, Last): Sam Conaway

18. MOTHER'S NAME (First, Middle, Maiden Surname): Claudie Bullins

19a. INFORMANT'S NAME (Type/Print): JoAnn Hopkins

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 527 Pontiac Avenue Baltimore, Maryland 21225

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Meadowridge Memorial Park
DATE: 4-1

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerome Zimmerman

22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home P.A.
4001 Ritchie Hwy. Baltimore, Md. 21225

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):	1 wk.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Ischemic Heart Disease DUE TO (OR AS A CONSEQUENCE OF):	5 yrs
c.	Insulin Dependent Diabetes DUE TO (OR AS A CONSEQUENCE OF):	20 yrs
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetic Nephropathy, Neuropathy & Retinopathy, Gastroparesis & Impotency, Foley, Colostomy, Gastrostomy

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER: D31744

29d. DATE SIGNED (Month, Day, Year): ▶ 3-30-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): MAR 31 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Pondexter

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DHMH-16 Rev 1/89

92 09087

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 4 is the permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph Frank ZIEMSKI		2. DATE OF DEATH (Month, Day, Year): March 27, 1992	3. TIME OF DEATH: 11:33 A M
4. SOCIAL SECURITY NUMBER: 213 07 7067	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 03/19/1904
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital Center	9b. CITY, TOWN OR LOCATION OF DEATH: Rossville 21237	9c. COUNTY OF DEATH: BBaltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore County	10c. CITY, TOWN OR LOCATION: Essex	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1309 Eastern Avenue	10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Builder	16b. KIND OF BUSINESS/INDUSTRY: Construction	
17. FATHER'S NAME (First, Middle, Last): Julius Ziemski	18. MOTHER'S NAME (First, Middle, Maiden Surname): Stella Kendezejski		
19a. INFORMANT'S NAME (Type/Print): Eleanor Ziemba (Daughter)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1314 Dorsey Avenue Baltimore MAryland 21221		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cem. DATE: 3/30/92	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home P.A 1407 Eastern Ave Baltimore Maryland 21221		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on aech lina.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finsl disease or condition resulting in death) →	a. Progressive CHF / Cardiomyopl	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery disease	
	DUE TO (OR AS A CONSEQUENCE OF): c. Chronic Atrial Fibrillation	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Hypertension
- Benign prostatic hypertrophy

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify)	28l. LOCATION (Street and Number or Rurel Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end menner as stated.
2 [ ] MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(e) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D31464	29d. DATE SIGNED (Month, Day, Yeer): 3/27/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. A. Hafshmi MD. 131 Back River Neck Rd, Balt MD

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

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92 09088

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWIN AUGUST STANISLAUS ANDRZEJEWSKI
2. DATE OF DEATH (Month, Day, Year): MARCH 29, 1992
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 213-03-8107
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-9-1916
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 2614 AMBLER ROAD
9b. CITY, TOWN OR LOCATION OF DEATH: DUNDALK
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: DUNDALK
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2614 AMBLER ROAD
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC DRIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): G.E.D. — College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FOREMAN - ROD & WIRE MILL BETHLEHEM STEEL CORP
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): STANISLAUS ANDRZEJEWSKI
18. MOTHER'S NAME (First, Middle, Maiden Surname): SALOMEA WEBER
19a. INFORMANT'S NAME (Type/Print): MARGARET R. ANDRZEJEWSKI
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2614 AMBLER ROAD BALTIMORE, MARYLAND 21222
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) — DATE: SACRED HEART OF JESUS 4/1/92
20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dregon E Rose
22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	PNEUMONIA	2 WKS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	ESOPHAGEAL CANCER	4 MO'S
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] OOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gary J Kerkvliet, MD
29c. LICENSE NUMBER: AF 232 8412 1384
29d. DATE SIGNED (Month, Day, Year): March 30, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GARY J. KERKVLIET 9000 FRANKLIN SQ DRIVE BALT MD 21237
31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09089
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Blair G Allison
2. DATE OF DEATH: MONTH 3 DAY 25 YEAR 92
3. TIME OF DEATH: 10:17 PM
4. SOCIAL SECURITY NUMBER: 211-18-3101
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/09/26
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): SUBURBAN HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA
9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: VA
10b. COUNTY: Prince William
10c. CITY, TOWN OR LOCATION: WOODBRIDGE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 1431 G St
10f. ZIP CODE: 22191
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: 1945-1946
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Personnell Clerk
16b. KIND OF BUSINESS/INDUSTRY: Department of Defense
17. FATHER'S NAME (First, Middle, Last): Harry Gibson Allison
18. MOTHER'S NAME (First, Middle, Maiden Surname): Emily Snyder
19a. INFORMANT'S NAME (Type/Print): Mrs. Virginia Allison
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1431 G Street Woodbridge, Virginia 22191
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Riverview Cemetery — DATE: 3/31/92
20c. LOCATION — City or Town, State: Hutingdon, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David D. Sm
22a. NAME AND ADDRESS OF FACILITY: Mountcastle Funeral Home 13318 Occoquan Rd. Woodbridge, VA

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. MYOCARDIAL INFARCTION — DUE TO (OR AS A CONSEQUENCE OF): — ACUTE
b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — DUE TO (OR AS A CONSEQUENCE OF): — INDEF
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 3 25 92
28b. TIME OF INJURY: 2130 M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: FOUND IN CAR
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): STREET
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt 270 + 355
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: FRANCIS C MAYLE
29c. LICENSE NUMBER: D07099
29d. DATE SIGNED (Month, Day, Year): 3-26-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): FRANCIS C MAYLE 8200 WISCONSIN AVE BETHESDA MD 20814
31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09090
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOUIS BENJAMIN
2. DATE OF DEATH (Month, Day, Year): 3 28 1992
3. TIME OF DEATH: 1 A. M
4. SOCIAL SECURITY NUMBER: 214-16-3951A
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/15/1916
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 3309 LEE CT.
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3309 LEE CT.
10f. ZIP CODE: 21208
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WWII - ARMY
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 1
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PROPRIETOR
16b. KIND OF BUSINESS/INDUSTRY: REAL ESTATE
17. FATHER'S NAME (First, Middle, Last): AARON BENJAMIN
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA ALPERSTEIN
19a. INFORMANT'S NAME (Type/Print): MRS. HARRIET BENJAMIN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3309 LEE CT. BALTIMORE, MD 21208
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HEBREW FRIENDSHIP — DATE: 3/30/92
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Cancer Colon with mets — 6 months

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David J. Mull
29c. LICENSE NUMBER: D0 6980
29d. DATE SIGNED (Month, Day, Year): 3/28/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David J. Mull 10219 S. Dolfield Rd. Owings Mills, Md.

31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: [signature] Davidson-Randall

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92 09091

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie A. Berry
2. DATE OF DEATH: MONTH 3 DAY 30 YEAR 92
3. TIME OF DEATH: 12 34 AM
4. SOCIAL SECURITY NUMBER: 216-24-4223
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 63 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-1-29
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore, City
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 627 Radnor Avenue
10f. ZIP CODE: 21212
10g. CITIZEN OF WHAT COUNTRY? U.S.A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+): B.S Degree
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Baltimore City Public Schools
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Walter Franklin
18. MOTHER'S NAME (First, Middle, Maiden Surname): Emily Knight
19a. INFORMANT'S NAME (Type/Print): Eddie Berry
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8047 Winding Wood Rd Glen Burnie, MD 21061
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland National Mem. Cem. DATE:
20c. LOCATION — City or Town, State: Laurel, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connie C. Benson
22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haert feilure. List only ona cause on aach lina.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Coronary Artery Disease	5 yr
DUE TO (OR AS A CONSEQUENCE OF): b.	Diabetes	20 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Hypertension	14 yrs
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO
25. WAS CASE REFERREO TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCUREO
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D19317
29d. DATE SIGNED (Month, Day, Year): 3/24/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4000 Old Court Rd. Suite 300 Balto MD 21208
31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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92 09092

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HENRIETTA E. BUECHLER
2. DATE OF DEATH: MONTH March DAY 30, YEAR 1992
3. TIME OF DEATH: 5:10 PM
4. SOCIAL SECURITY NUMBER: 401-03-2892
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): July 8, 1908
8. BIRTHPLACE (State or Foreign Country): Indiana
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2613 Moore Avenue
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATNER'S NAME (First, Middle, Last): (Not Known) Gardey
18. MOTNER'S NAME (First, Middle, Maiden Surname): (Not Known)
19a. INFORMANT'S NAME (Type/Print): Helen M. Huebel
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8625A Oakleigh Rd. Baltimore, Md. 21234
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial 4/2/92 DATE
20c. LOCATION — City or Town, State: Baltimore Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Milton J. Knight Jr
22. NAME AND ADDRESS OF FACILITY: Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Road

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Probable Myocardial Rupture	20 minutes
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	ACUTE MYOCARDIAL INFARCTION	1 DAY
c. DUE TO (OR AS A CONSEQUENCE OF):	CORONARY ARTERY DISEASE	YEARS.
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [/] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [/] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD
29c. LICENSE NUMBER: H-0
29d. DATE SIGNED (Month, Day, Year): 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 7601 North Rayon Blvd, Baltimore, MD 21239.
31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: Gina Davidson-Yandell

DHMH-16 Rev 1/89

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92 09093

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frederick R. BOHLEN
2. DATE OF DEATH (Month, Day, Year): 03 27 92
3. TIME OF DEATH: 11:27 A M
4. SOCIAL SECURITY NUMBER: 215-34-2406
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/18/23
8. BIRTHPLACE (State or Foreign Country): Baltimore Co.
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 5318 East Avenue
10f. ZIP CODE: 21206
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES: X
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer
16b. KIND OF BUSINESS/INDUSTRY: Self-Employed
17. FATHER'S NAME (First, Middle, Last): Frederick J. Bohlen
18. MOTHER'S NAME (First, Middle, Maiden Surname): Augusta Minnie Hawkins
19a. INFORMANT'S NAME (Type/Print): Florence Bohlen
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5318 East Ave. Baltjmore, Maryland 21206
20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cem. DATE: 3/30/92
20c. LOCATION — City or Town, State: Baltimore, maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lassahn Funeral Home
22. NAME AND ADDRESS OF FACILITY: Lassahn Funeral Home 7401 Bolair Rd. Balto, Md. 21236

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory srreet, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
Sequentielly list conditions, if any, leading to immediete cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST
b. Arteriosclerotic Heart Disease — 12yr.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditione contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Robert J. Lyden M.D.
29c. LICENSE NUMBER: D06272
29d. DATE SIGNED (Month, Day, Year): 3/28/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT J. LYDEN, M.D. 6402 GOLDEN RING RD. BALT MD
31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: [illegible]

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09094
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GERTRUDE E. BEEMAN

2. DATE OF DEATH (Month, Day, Year): 3 30 92

3. TIME OF DEATH: 10:42 P M

4. SOCIAL SECURITY NUMBER: 578-07-5137

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 89 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): JULY 24, 1902

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE

9c. COUNTY OF OEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLADN

10b. COUNTY: CARROLL COUNTY

10c. CITY, TOWN OR LOCATION: UNION BRIDGE

10d. INSIOE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 8906 DOLLYHYDE ROAD

10f. ZIP CODE: 21791

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify: X

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 8TH GRADE
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): JAMES T. WOODALL

18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSE M. ROBEY

19a. INFORMANT'S NAME (Type/Print): ETHEL M . MARTIN

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8906 DOLLYHYDE RD., UNION BRIDGE,MD. 21791

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, cremetory or other piece): LOUDON PARK CEMETERY — DATE: 4/3

20c. LOCATION — City or Town, State: BALTIMORE

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Louis E. Smith

22. NAME AND ADDRESS OF FACILITY:

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the disesses, or complicstions thet ceused the death. Do not snter the mode of dying, such as cerdiec or raspiratory arreet, shock, or heart failure. List only one ceuse on eech line.

Approximste Interval Between Onset and Death

IMMEDIATE CAUSE (Finsl disease or condition resulting in death) →
a. Acute exacerbation of COPD
OUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediets cause. Enter UNDERLYING CAUSE (Disease or injury thst initiated events resulting in desth) LAST
b.
OUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying ceuee given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERREO TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF OEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. OESCRIBE HOW INJURY OCCURED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, Stste):

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, end dus to the cause(s) end menner es stated.

29b. SIGNATURE ANO TITLE OF CERTIFIER: Sankaranadan S

29c. LICENSE NUMBER: St Agnes Hospital

29d. DATE SIGNED (Month, Day, Year): 3-30-92

30. NAME ANO AOORESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): S. SIVASAILAM. St Agnes Hospital 900 Caton ave. Baltimore MD-21229

31. DATE FILEO (Month, Day, Year): APR 1 1992

32. REGISTRAR'S SIGNATURE: Sue Davidson-Randall

DHMH-16 Rev 1/89

92 09095

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SARAH BRAUNSTEIN
2. DATE OF DEATH (Month, Day, Year): MAR. 29, 1992
3. TIME OF DEATH: 8:15 a. M
4. SOCIAL SECURITY NUMBER: 800-02-3753
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): MAY 10, 1909
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 3821 BRENBROOK DR.
9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6021 WESTERN RUN DR.
10f. ZIP CODE: 21209
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: AT HOME
17. FATHER'S NAME (First, Middle, Last): SAMUEL SILVERMAN
18. MOTHER'S NAME (First, Middle, Maiden Surname): REBECCA (UNKNOWN)
19a. INFORMANT'S NAME (Type/Print): STEWART BRAUNSTEIN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 24 BARTHEL CT. LUTHERVILLE, MD 21093
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): SHAAREI ZION — DATE: 3/31/92
20c. LOCATION — City or Town, State: ROSEDALE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joel D Lewis
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Adenocarcinoma of lung — ~2 yrs

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Ian B Hoffman MD
29c. LICENSE NUMBER: D 39845
29d. DATE SIGNED (Month, Day, Year): 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ian Hoffman MD 4000 old Court Rd. Suite 306 Baltimore 21208
31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

12

92-1787-510

92 09096

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
JESSIE P.		BURNETT	03 27 1992	6:17 P.M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
229-16-8998	1 [X] M 2 [ ] F	68 YRS.			1/24/1924	Virginia

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
BON SECOUR HOSPITAL	BALTIMORE CITY	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD.		Baltimore City	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2700 Talbot Road Apt A	21216	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: Negro

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Jesse A. Burnett	Mary Virginia Bentley

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gwendolyn Burnett	2700 Talbot Rd. Balto,Md. 21216

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Woodlawn Cemetery	4/2	Balto. County,Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Joseph L. Russ	Joseph L. Russ Funeral Home 2222 West North Ave Balto Md. 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
[X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
A. M. DIXON	O.C.M.E.	▶ 03-28-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
A. M. DIXON 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 1 1992	Julia Davidson-Burnett

DHMH-16 Rev 1/89

92 09097

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROSE M. CONNOLLY			2. DATE OF DEATH (Month, Day, Year): 3 28 92	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 215-46-7875	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-30-1903	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): RIVERVIEW NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: ESSEX		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: EDGEMERE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3225 LYNCH ROAD		10f. ZIP CODE: 21219	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6TH GRADE; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER	16b. KIND OF BUSINESS/INDUSTRY: HOME	
17. FATHER'S NAME (First, Middle, Last): WILLIAM HARTMAN	18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSELLA TUTTLE		
19a. INFORMANT'S NAME (Type/Print): JOHN C. CONNOLLY	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3225 LYNCH ROAD BALTIMORE, MARYLAND 21219		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK LAWN CEMETERY 3-31-1992	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PULMONARY EMBOLUS	2 mo
	DUE TO (OR AS A CONSEQUENCE OF): CVA	2 yrs
Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): DIABETES MELLITUS	5 yrs
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Norman R Kleiman MD	MD-D09019	▶ 3/28/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NORMAN R KLEIMAN MD. 3803 EDMONDSON AVE BALTO MD 21229

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 01 1992	Julia Davidson-Randall

DHMH-16 Rev 1/89

4

Items 2,3 per MEO, G-686, 4/28/92 gn

92-1790-031

92 09098

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial/removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Russell Todd Cody

2. DATE OF DEATH Month: 3 Day: ~~28~~ 27 Year: 92

3. TIME OF DEATH: ~~12:30 A.~~ 11:20 PM

4. SOCIAL SECURITY NUMBER: 261-11-2255

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 27 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): JULY 24, 1964

8. BIRTHPLACE (State or Foreign Country): FLORIDA

9a. FACILITY NAME (If not institution, give street and number): 307 Scott Drive

9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: MONTGOMERY

10c. CITY, TOWN OR LOCATION: SILVER SPRING

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 307 SCOTT DRIVE

10f. ZIP CODE: 20933

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES: X

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 3 YRS

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STUDENT

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): ARTHUR P. CODY

18. MOTHER'S NAME (First, Middle, Maiden Surname): RUTH C. BORDER

19a. INFORMANT'S NAME (Type/Print): ARTHUR P. CODY

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3604 ALTOONA DRIVE - TALLAHASSEE, FLORIDA 32308

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOWWOOD CEMETERY — DATE: 4/1

20c. LOCATION — City or Town, State: TALLAHASSEE, FLORIDA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶

22. NAME AND ADDRESS OF FACILITY: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hanging DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): Found 3-27-92

28b. TIME OF INJURY: Found 11:20P.M.

28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO

28d. DESCRIBE HOW INJURY OCCURED: Subject Hanged Self

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home

28f. LOCATION (Street and Number or Rural Route Number, City or State): 307 Scott Drive

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER:

29c. LICENSE NUMBER: O.C.M.E.

29d. DATE SIGNED (Month, Day, Year) ▶: 3-28-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Anderson 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): APR 1 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

3

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09099 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Ruth COBURN					2. DATE OF DEATH: March 31 1992	3. TIME OF DEATH: 12:25 am M
4. SOCIAL SECURITY NUMBER: 216-18-6878	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 07-15-1920	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore County	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore County	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5124 McFaul Road		10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fiscal Clerk	16b. KIND OF BUSINESS/INDUSTRY: State of Maryland	
17. FATHER'S NAME (First, Middle, Last): Edward Frankhouser		18. MOTHER'S NAME (First, Middle, Maiden Surname): Dora Thomas	
19a. INFORMANT'S NAME (Type/Print): Benjamin H. Coburn, III	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2945 Hearthstone Road, Ellicott City, Maryland 21042		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial	DATE: 4/3	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathleen M. Murphy	22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Sepsis

DUE TO (OR AS A CONSEQUENCE OF):
b. Pyelonephritis of right kidney, severe

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. Cardiomegaly with left ventricular and interventricular septal
DUE TO (OR AS A CONSEQUENCE OF):
d. hypertrophy

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
☒ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Gabriel Soudry MD		▶ 5/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Gabriel Soudry, M. D. 9000 Franklin Square Drive - 21237

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 1 1992	Lidia Davidson-Kendall

DHMH-18 Rev 1/89

92 09100

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evans, Jeanne Louise			2. DATE OF DEATH (Month, Day, Year): 3-26-92	3. TIME OF DEATH: 1920 M
4. SOCIAL SECURITY NUMBER: 173 20 6604	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS. (If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.)	7. DATE OF BIRTH (Month, Day, Year): 1/30/24	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Takoma Park.		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 7520 Maple Avenue # 108		10f. ZIP CODE: 20912		10g. CITIZEN OF WHAT COUNTRY?
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Henry Edwards		18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva Cardwell		
19a. INFORMANT'S NAME (Type/Print): Debra G. Evans		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7520 Maple Avenue Apt. 108 Takoma Park, Md		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Homestead Cemetery	DATE: 3 31 92	20c. LOCATION — City or Town, State: Munhall, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Ives-Pearson F H 2847 Wilson Blvd. Arlington, Va. 22201			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet ceused the death. Do not enter the mode of dying, such ee cerdiec or reepiratory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Deeth

IMMEDIATE CAUSE (Finel disease or condition reeulting in death) →
e. MYOCARDIAC INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted events reeulting in deeth) LAST
b. CORONARY ARTERY DISEASE

DUE TO (OR AS A CONSEQUENCE OF):
c. DIABETES

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditions contributing to deeth but not reeulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Hector C. Collison	02625	▶ 3/29/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Hector Collison M.D. 1111 Spring St. Silver Spring, MD 20910

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 01 1992	Julia Davidson-Randall

DHMH-16 Rev 1/89

92-1779-510

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09101 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PEREZ FERNANDO PEREZ			2. DATE OF DEATH (Month, Day, Year): 03 27 1992	3. TIME OF DEATH: 8:30 A.M
4. SOCIAL SECURITY NUMBER: 217-68-1581	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 31 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6-12-60	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 218 N.WOLFE STREET			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1752 GORSUCH AVENUE		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): ISAAC PEREZ		18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE McDUFFIE	
19a. INFORMANT'S NAME (Type/Print): ANNIE M. PEREZ		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1752 GORSUCH AVE./BALTIMORE, MD 21218	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MT. CALVARY CEMETERY	DATE:	20c. LOCATION — City or Town, State: ANNE ARUNDEL CO, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lynette K. Jones		22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CONTACT GUNSHOT WOUND OF HEAD	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b.	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 03-27-1992	28b. TIME OF INJURY: 7:45A M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: SELF INFLICTED GUNSHOT WOUND
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): AT HOME			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 218 N.WOLFE STREET

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Marjorie Smith Gill	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): 03-27-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARJORIE A. GILL MD	111 PENN STREET BALTIMORE MARYLAND 21201	
31. DATE FILED (Month, Day, Year): APR 01 1992	32. REGISTRAR'S SIGNATURE: Lina Davidson-Randall	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09102
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CARLOS B. FAHRMEIER
2. DATE OF DEATH (Month, Day, Year): 03 28 1992
3. TIME OF DEATH: 7:25P M
4. SOCIAL SECURITY NUMBER: 218-16-9891
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 68 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 03 12 1924
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): G.B.M.C., 6701 N. CHARLES ST.
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 30 BARDEEN CT.
10f. ZIP CODE: 21204
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tax Accountant
16b. KIND OF BUSINESS/INDUSTRY: Robert C. Hazard Co.
17. FATHER'S NAME (First, Middle, Last): Walter S. Barnes
18. MOTHER'S NAME (First, Middle, Maiden Surname): Edith Carroll
19a. INFORMANT'S NAME (Type/Print): David E. Fahrmeier
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1122 Overbrook Rd. 21239
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): New Spring Hill Cemetery — DATE: 4/3/92
20c. LOCATION — City or Town, State: Easton , Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: 1050 York Rd, 21204 — Ruck Towson Funeral Home, Inc.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. CARDIOPULMONARY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. RENAL FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recurrent Ovarian Carcinoma

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Francis C. Grumbine
29c. LICENSE NUMBER: D.20637
29d. DATE SIGNED (Month, Day, Year) ▶ 3-30-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Francis C. Grumbine M.D., 6701 N. Charles Street

31. DATE FILED (Month, Day, Year): APR 01 1992
32. Signature — Registrar

IMPORTANT: If item 29 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO BE COMPLETED BY THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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92 09103

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Okely Irene Frances
2. DATE OF DEATH (Month, Day, Year): MARCH 30, 1992
3. TIME OF DEATH: 6:50 A M
4. SOCIAL SECURITY NUMBER: 229-38-4276
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 58 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): May 20 1933
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Phoenix
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2315 Carroll Mill Road
10f. ZIP CODE: 21131
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Receiving Clerk
16b. KIND OF BUSINESS/INDUSTRY: Medical Device Mfg.
17. FATHER'S NAME (First, Middle, Last): Floyd Francis Ball
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ada Smith
19a. INFORMANT'S NAME (Type/Print): C. Ray Frances
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2315 Carroll Mill Rd., Phoenix, Md. 21131
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Ketrons Cemetery — DATE: 4/3/92
20c. LOCATION — City or Town, State: Lebanon, Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Martin D. Lawson
22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd., Timonium, Md. 21093

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Hypotension	4 hours
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Myocardial infarction	5 hours
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Ischemic cardiomyopathy	5 years
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: Diabetes mellitus, Hyperlipidemia, Epidermal necrosis, Hepatic congestion

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Stuart C. Ray MD
29c. LICENSE NUMBER: J2126
29d. DATE SIGNED (Month, Day, Year): 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 600 N. WOLFE ST. BALTIMORE, MD 21205
31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Hopkins

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92-1833-510

92 09104

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jerry Goldberg, Jr.			2. DATE OF DEATH (Month, Day, Year): 03 31 1992	3. TIME OF DEATH: 1:42 AM
4. SOCIAL SECURITY NUMBER: 215-17-0269	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 18 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 08 05 73	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3813 Hudson Street		10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11	College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Unemployed	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Jerry Goldberg Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Donna Foehrkolb	
19a. INFORMANT'S NAME (Type/Print): Jerry Goldberg Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3813 Hudson St. Balto., Md. 21224	

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cem	DATE: 4-3-92	20c. LOCATION — City or Town, State: Dundalk, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles D. Zeiler		22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 901 S. Conkling St.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple Stab Wounds	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) on street		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 03 31 1992	28b. TIME OF INJURY: 12:24A M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Subject stabbed
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): on street			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2700 blk. Creston

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ 03 31 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ernie J. Gerettim	111 Penn Street, Baltimore Maryland 21201	
31. DATE FILED (Month, Day, Year): APR 0 1 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09105

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mildred Helen Garland		2. DATE OF DEATH (Month, Day, Year): 03/25/92	3. TIME OF DEATH: 3:50 A M
4. SOCIAL SECURITY NUMBER: 295-32-5404	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 03/07/25
8. BIRTHPLACE (State or Foreign Country): Kentucky			
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: City	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3540 Fieldcreek Way	10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Calvin Davenport	18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Slaven		
19a. INFORMANT'S NAME (Type/Print): Fred Kanet	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3540 Fieldcreek Way Baltimore, MD. 21234		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Barren Fork Cemetery 03/28/92	20c. LOCATION — City or Town, State: Whitley City, Kentucky	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John J. Dippel	22. NAME AND ADDRESS OF FACILITY: Dippel Funeral Home, Inc. 7110 Belair Road Baltimore, MD. 21206		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CoPD Exacerbation	Hours
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Baseline CoPD	years
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Para Pneum

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: FRED TACKEY M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): 03/25/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Fred Tackey, M.D. Good Samaritan Hospital 5601 Loch Raven Boulevard		
31. DATE FILED (Month, Day, Year): APR 0 1 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09106
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thomas F. Gillespie, Sr.

2. DATE OF DEATH (Month, Day, Year): 3/27/92

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 182-10-7345

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 80 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS
IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 9/9/11

8. BIRTHPLACE (State or Foreign Country): Philadelphia

9a. FACILITY NAME (If not institution, give street and number): 3607 Stansbury Mill Rd.

9b. CITY, TOWN OR LOCATION OF DEATH: Phoenix, Maryland

9c. COUNTY OF OEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Phoenix

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 3607 Stansbury Mill Rd.

10f. ZIP CODE: 21131

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR OATES: WW II

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.)
1 [ ] YES 2 [X] NO Specify: XX

14. RACE — American Indian, Black, Whita, etc. Specify: White

15. DECEDENT'S EOUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4 or 5+):

16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Driver

16b. KIND OF BUSINESS/INDUSTRY: Holland Laundry

17. FATHER'S NAME (First, Middle, Last): John Gillespie

18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Fitzpatrick

19a. INFORMANT'S NAME (Type/Print): Thomas F. Gillespie, Jr.

19b. MAILING ADOREss (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3607 Stansbury Mill Rd. Phoenix, Md. 21131

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Highview Memorial gardens

OATE: 3.31.92

20c. LOCATION — City or Town, State: Baltimore, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ E.F. Lassahn Funeral Home

22. NAME ANO ADDRESS OF FACILITY: E.F. Lassahn Funeral Home
11750 Belair Rd. Baltimore, Maryland 21087

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseeses, or complicetione that caused the deeth. Do not enter the mode of dying, such aa cerdiac or reapiratory arrest, ehock, or haert failure. Liet only one ceuse on eech line.

Approximate Intarvel Between Onset and Daath

IMMEDIATE CAUSE (Finel diseese or condition resulting in death) →
a. Metastatic Adenocarcinoma of Lung
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
OUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and piece, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Walter Hepner

29c. LICENSE NUMBER: D23450

29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92

30. NAME ANO AOORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Walter Hepner M.D. Phoenix, Md.

31. DATE FILEO (Month, Day, Year): APR 0 1 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

OHMH-16 Rev 1/89

92 09107

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 or 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNIE W. GIBSON					2. DATE OF DEATH: MONTH 3 DAY 28 YEAR 1992	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 217-09-0177	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 8/13/1912	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): IRVINGTON NURSING HOME			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY			9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT						
10a. STATE: MD.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY				10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1510 N. PULASKI STREET		10f. ZIP CODE: 21217			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: NEGRO	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER			16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): HARRY THOMAS WATSON					18. MOTHER'S NAME (First, Middle, Maiden Surname): MINNIE MOORE	
19a. INFORMANT'S NAME (Type/Print): JESSIE RUFFIN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1510 N. PULASKI STREET, BALTO, MD. 21217				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS Mem. Park	DATE		20c. LOCATION — City or Town, State: Balto. Co. Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ		22. NAME AND ADDRESS OF FACILITY: JOSEPH L. RUSS FUNERAL HOME 2222 W. NORTH AVE, BALTO, MD. 21216				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Atherosclerotic cardiovasc. disease	yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hip Fract. femur frt	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Non contributary to death	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Amatun N Naeem	D15503	▶ 3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AMATUN N NAEEM, 501 Dolphin St, Balto, MD 21217

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 1 1992	Julia Davidson-Randall

DHMH 16 Rev 1/89

92 09108

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kathryn Louise Hines
2. DATE OF DEATH (Month, Day, Year): March 29 92
3. TIME OF DEATH: 9:45 P M
4. SOCIAL SECURITY NUMBER: 214 18 0326
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec. 22, 1912
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): HARFORD Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: HAVRE DE GRACE
9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: HARFORD
10c. CITY, TOWN OR LOCATION: HAVRE deGRACE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 40 Robin Hood Road
10f. ZIP CODE: 21078
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 YRS. — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): At Home
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): GARNETT DILWORTH
18. MOTHER'S NAME (First, Middle, Maiden Surname): ADA SEWARD
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): GARDENS OF FAITH — DATE: 4-2-92
20c. LOCATION — City or Town, State: ROSEDALE MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Respiratory arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. COPD,
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST
c. transverse Colostomy for bowel obstruction
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Brian T Yon MD
29c. LICENSE NUMBER: D15752
29d. DATE SIGNED (Month, Day, Year): 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 801 S. Union Ave; Havre De Grace, MD 21078
31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09109
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOUGLASS CARROLL HANSON
2. DATE OF DEATH (Month, Day, Year): 3 26
3. TIME OF DEATH: 1107p M
4. SOCIAL SECURITY NUMBER: 214-62-8599
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 38 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 12-24-53
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): FRANCES SCOTT KEY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: TURNERS STATION
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 513 MAIN STREET
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): FLOYD HANSON
18. MOTHER'S NAME (First, Middle, Maiden Surname): PATSY HOPKINS
19a. INFORMANT'S NAME (Type/Print): BENNIE HANSON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4905 LANIER AVE. APT. B/BALTIMORE, MD 21215
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK
DATE:
20c. LOCATION — City or Town, State: ARBUTUS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hesrt failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pneumococcal meningITIS
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HIV INFECTION
LIVER CIRRHOSIS

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David B Pearce MD
29c. LICENSE NUMBER: D29308
29d. DATE SIGNED (Month, Day, Year): ▶ 3/26/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: [signature]

IMPORTANT: If item 29 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

OHMH-16 Rev 1/89

92-1824-510

92 09110

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DEXTER Lewis HORTON JR.			2. DATE OF DEATH (Month, Day, Year): 03 30 1992	3. TIME OF DEATH: 11:00 AM
4. SOCIAL SECURITY NUMBER: 218-86-0226	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 21 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-4-70	8. BIRTHPLACE (State or Foreign Country): md
9a. FACILITY NAME (If not institution, give street and number): JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: md	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Balto.	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 912 E. 20th St.		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: U.S.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Negro

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): unemployed	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Dexter Lewis Horton Sr.		16. MOTHER'S NAME (First, Middle, Maiden Surname): Robin Jones	
19a. INFORMANT'S NAME (Type/Print): Robin Jones		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 912 E. 20th St. Balto. md 21218	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Arbutus Memorial DATE: 4/1	20c. LOCATION — City or Town, State: Arbutus md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Betts Funeral Home		22. NAME AND ADDRESS OF FACILITY: 1129 N. Caroline st	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Gunshot Wound of Head
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 03-30-1992	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: SUBJECT SHOT			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): ON STREET	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2600 BLK. HARFORD ROAD		

29e. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ 03-31-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK J. PERETTI M.D. 111 PENN STREET BALTIMORE MARYLAND 21201		
31. DATE FILED (Month, Day, Year): APR 0 1 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

5

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09111

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SHARON Y. HILL
2. DATE OF DEATH (Month, Day, Year): MARCH 29, 1992
3. TIME OF DEATH: 8:11 A M
4. SOCIAL SECURITY NUMBER: 577-72-9230
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 39 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-15-52
8. BIRTHPLACE (State or Foreign Country): Willington N.C.
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2324 Callow Avenue
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Clarence Hands
16. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Lacewell
19a. INFORMANT'S NAME (Type/Print): Dr. Allen Bennett
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7101 Campfield Rd. Balti. Md.
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery — DATE: 4/1
20c. LOCATION — City or Town, State: Baltimore
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Eugene R Price
22. NAME AND ADDRESS OF FACILITY: Eugene R. Price Funeral Home, 108 W. North Ave. Balti. Md. 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PNEUMOCOCCAL SEPSIS — 48 D
DUE TO (OR AS A CONSEQUENCE OF):
b. AIDS — 2 yrs.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
~~TTP~~ [illegible]
THROMBOTIC THROMBOCYTOPENIC PURPURA
INSULIN DEPENDENT DIABETES MELLITUS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Michael T. Chin M.D. — MICHAEL T. CHIN, MD, PhD.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THE JOHNS HOPKINS HOSPITAL
31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09112 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Beatrice HAYES
2. DATE OF DEATH (Month, Day, Year): March 27 1992
3. TIME OF DEATH: 6:25 AM
4. SOCIAL SECURITY NUMBER: 218-18-7978
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 73 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/5/18
8. BIRTHPLACE (State or Foreign Country): Baltimore
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4104 Putty Hill Ave,
10f. ZIP CODE: 21236
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Homekeeping
17. FATHER'S NAME (First, Middle, Last): Conrad George Neumeister
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lottie W. Voelkel
19a. INFORMANT'S NAME (Type/Print): Frederick Hayes
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4104 Putty Hill Ave. Balto., Maryland 21236
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Peter's Cem. DATE: 3/30/92
20c. LOCATION — City or Town, State: Baltimore
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard A Hess
22. NAME AND ADDRESS OF FACILITY: Lassahn FH 7401 Belair Rd. 21236

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Irreversible brain anoxia
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Ventricular arrhythmia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: RLaforce MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 3/21/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Laforce 9000 Franklin Sq. Dr. Balto, MD 21237

31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

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9000 Franklin Sq.

92 09113

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Catherine Elizabeth Hudson		2. DATE OF DEATH (Month, Day, Year): March 28, 1992	3. TIME OF DEATH: 5:00 p M
4. SOCIAL SECURITY NUMBER: 208 22 4270A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 20 1910
8. BIRTHPLACE (State or Foreign Country): Pa			
9a. FACILITY NAME (If not institution, give street and number): 10759 Grey's Corner Road	9b. CITY, TOWN OR LOCATION OF DEATH: Berlin	9c. COUNTY OF DEATH: Worcester	

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: Worcester	10c. CITY, TOWN OR LOCATION: Berlin	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 10759 Grey's Corner Road		10f. ZIP CODE: 21811	10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 15	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurse	16b. KIND OF BUSINESS/INDUSTRY: Nursing
17. FATHER'S NAME (First, Middle, Last): Samuel T. Gray		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jennie Tome	
19a. INFORMANT'S NAME (Type/Print): Jack Dunlap		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 140, Berlin, Md. 21811	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bishopville Cemetery	20c. LOCATION — City or Town, State: Bishopville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. Erik Burbage		22. NAME AND ADDRESS OF FACILITY: Burbage Funeral Home, 108 Williams St. Berlin, Md. 2181	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive Heart Failure, Severe
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Aortic Stenosis
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Andres C. Gomez MD	29c. LICENSE NUMBER: D0231?	29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Andres C. Gomez, MD 105 65th St. Ocean City, Md. 21842

31. DATE FILED (Month, Day, Year): APR 01 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09114

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANCIS G HURLOCK
2. DATE OF DEATH (Month, Day, Year): 03 30 92
3. TIME OF DEATH: 09:35A M
4. SOCIAL SECURITY NUMBER: 214 07 9115
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 77 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11 01 14
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALTIIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3033 PINEWOOD AVE
10f. ZIP CODE: 21214
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — Americen Indien, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Metallurgist
16b. KIND OF BUSINESS/INDUSTRY: American Smelting
17. FATHER'S NAME (First, Middle, Last): Frank A. Hurlock
18. MOTHER'S NAME (First, Middle, Maiden Surname): Eulah M. Geoghegan
19a. INFORMANT'S NAME (Type/Print): Hilda S. Hurlock
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3033 Pinewood Ave., Baltimore, MD. 21214
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory — DATE: 3-31
20c. LOCATION — City or Town, State: Baltimore, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Grove Altenburg
22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one cause on aech lina.

Approximate Interval Between Onset and Daeth

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. Adenocarcinoma of Lung — Approximate Interval: ±2 mo

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediete cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.: ASCVD

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATN (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward P. Costlow MD
29c. LICENSE NUMBER: D19503
29d. DATE SIGNED (Month, Day, Year): ▶ 3 30 92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): EP COSTLOW MD 10 GERARD AVE 214 TIMONIUM RD 21093.

31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: [illegible]

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92-1808-510

92 09115

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Herman Junior Hazlett
2. DATE OF DEATH (Month, Day, Year): 3 29 92
3. TIME OF DEATH: 12:55 A.M
4. SOCIAL SECURITY NUMBER: 215-80-8316
5. SEX: 1 [X] M 2 [ ] F
6. AGE (If yrs. last birthday): 27 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Apr. 24, 1964
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2810 Evergreen Ave.
10f. ZIP CODE: 21214
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Apprentice
16b. KIND OF BUSINESS/INDUSTRY: Electric
17. FATHER'S NAME (First, Middle, Last): Herman Hazlett, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Pellens
19a. INFORMANT'S NAME (Type/Print): Sherrie L. Hazlett
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2810 Evergreen Ave., Baltimore, MD 21214
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory — DATE: 3/30
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. Glenn Altenburg
22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact Gunshot Wound of Head (Intracranial)
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO — Head only
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 3-29-92
28b. TIME OF INJURY: 12:06A.M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: Self Inflicted Gunshot Wound
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Street
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 3100 Block Royston Ave.
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): 3-29-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] 111 Penn Street, Baltimore, Maryland 21201
31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: Lina Davidson-Randall

DHMH-16 Rev 1/89

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92 09116

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Herman F. HENSS, Sr.						2. DATE OF DEATH (Month, Day, Year): March 29 1992	3. TIME OF DEATH: 11:30 pm. M
4. SOCIAL SECURITY NUMBER: 216-05-3103	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		7. DATE OF BIRTH (Month, Day, Year): 7-27-1908	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore				9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT							
10a. STATE: Md.	10b. COUNTY: --------		10c. CITY, TOWN OR LOCATION: Baltimore				10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3010 Orlando Ave.			10f. ZIP CODE: 21234				10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chauffeur				16b. KIND OF BUSINESS/INDUSTRY: Meat Packing Co.
17. FATHER'S NAME (First, Middle, Last): FRederick Henss						18. MOTHER'S NAME (First, Middle, Maiden Surname): Helena Hebbel	
19a. INFORMANT'S NAME (Type/Print): Mr. Herman F. Henss, Jr.			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3010 Orlando Ave. Balto., Md. 21234				
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cemetery		DATE: 4/2	20c. LOCATION — City or Town, State: Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jody S. Miskimen			22. NAME AND ADDRESS OF FACILITY: Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Secondary to Continued Aspiration	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Stroke Hypertension, Cortical Blindness

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
X MD	N/A	▶ 3/29/91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dana Coates, MD. 9000 Franklin Square Drive, Baltimore, Maryland 21237

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 0 1 1992	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09117
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN JOSEPH ILGENFRITZ, SR.
2. DATE OF DEATH (Month, Day, Year): MAR. 27, 1992
3. TIME OF DEATH:
4. SOCIAL SECURITY NUMBER: 212-05-4959
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): MAR. 8, 04
8. BIRTHPLACE (State or Foreign Country): BALTIMORE MD.
9a. FACILITY NAME (If not institution, give street and number): 3107 GARDEN AVE 21234
9b. CITY, TOWN OR LOCATION OF DEATH: PARKVILLE
9c. COUNTY OF DEATH: BALTIMORE CO.

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: BALTIMORE CO.
10c. CITY, TOWN OR LOCATION: PARKVILLE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3107 GARDEN AVE
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 2
16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BALTO. GAS + ELECTRIC
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): ALBERT L. ILGENFRITZ
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET CONNOLLY
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEM. — DATE: 3-31
20c. LOCATION — City or Town, State: PARKVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey L. Gair
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 3300 HARFORD ROAD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hx of atrial fibrillation
Hx of hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) Home
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Beverly J. Kelsey
29c. LICENSE NUMBER: D32418
29d. DATE SIGNED (Month, Day, Year): 3 / 92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. BEVERLY KELSEY 5600 LOCH RAVEN BLVD.
31. DATE FILED (Month, Day, Year): APR 0 1 1992
Julia Davidson Randall

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09118
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT KROLIKOWSKI / Robert P. Krolikowski
2. DATE OF DEATH MONTH: 03 DAY: 26 YEAR: 92
3. TIME OF DEATH: 1730 M
4. SOCIAL SECURITY NUMBER: 173 20 0819
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 30, 1928
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Rockville
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Gaithersburg
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11900 Fernshire Road
10f. ZIP CODE: 20878
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant
16b. KIND OF BUSINESS/INDUSTRY: American Institute for Research
17. FATHER'S NAME (First, Middle, Last): John Krolikowski
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Patric
19a. INFORMANT'S NAME (Type/Print): Mary Jane Krolikowski
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Queen of Heaven Cemetery
20c. LOCATION — City or Town, State: Bridgeville, Washington Co., Penna.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David L. Sauers
22. NAME AND ADDRESS OF FACILITY: Capitol Funeral Service, Falls Church, VA

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cerdiac or reepiretory arrest, shock, or heart failure. List only one ceuee on eech line.

		Approximate Interval Between Onset end Death
IMMEDIATE CAUSE (Finel diseese or condition reeulting in death) →	e. acute respiratory failure	10 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediete cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events reeulting in death) LAST	b. respiratory arrest (probable CA)	2 hrs
DUE TO (OR AS A CONSEQUENCE OF):		
	c. severe chronic obstructive pulmonary disease	25 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
	d. old TB	40 yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Macular degeneration

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Ronald E. Lyon
29c. LICENSE NUMBER: 014660
29d. DATE SIGNED (Month, Day, Year): 3/26/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 15001 Outlet Mill Rd Gaithersburg, MD 20878
31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: Julia Burdon-Rutledge

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09119
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. DECEDENT'S NAME (First, Middle, Last): FANNIE KIRSH

2. DATE OF DEATH Month: 3 Day: 28 Year: 92

3. TIME OF DEATH: 5 PM M

4. SOCIAL SECURITY NUMBER: 213-48-5267

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 87 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 3/28/1905

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): PIKESVILLE NURSING HOME

9b. CITY, TOWN OR LOCATION OF DEATH: PIKESVILLE

9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? XX 1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER: 3737 CLARKS LA.,APT. 301

10f. ZIP CODE: 21215

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES X

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE

16b. KIND OF BUSINESS/INDUSTRY: AT HOME

17. FATHER'S NAME (First, Middle, Last): SINION TREPOLSKY

18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA POLLACK

19a. INFORMANT'S NAME (Type/Print): MRS. EILEEN MILLER

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2903 FALLSTAFF RD., UNIT 508 BALTO.,MD 21209

20a. METHOD OF DISPOSITION: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): BETH TFILOH — DATE: 3/30/92

20c. LOCATION — City or Town, State: BALTIMORE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joel D Lewis

22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS.,INC. 6010 REISTERSTOWN RD. BALTO.,MD 21215

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Broken Femur	3 DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	ARTERIO	15 YRS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CATH M.I. DEMENTIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY M:

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Raymond F. Kaplan M.D.

29c. LICENSE NUMBER: D 04601

29d. DATE SIGNED (Month, Day, Year): 3/29/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAYMOND F. KAPLAN M.D. 1717 REISTERSTOWN RD 21208

31. DATE FILED (Month, Day, Year): APR 01 1992

32. REGISTRAR'S SIGNATURE: Davidson-Randall

DHMH-16 Rev 1/89

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D111834-2082
KERSH CELIA
03/22/92 BALARD

92 09120

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CELIA KERSH

2. DATE OF DEATH: MONTH 03 DAY 28 YEAR 92

3. TIME OF DEATH: 12:00 NOON

4. SOCIAL SECURITY NUMBER: 218-54-2809

5. SEX: 1 ☐ M 2 ☑ F

6. AGE (In yrs. last birthday): 91 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 12-01-00

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 3904 FORDLEIGH RD., APT. A

10f. ZIP CODE: 21215

10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR OATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNKNOWN

16b. KIND OF BUSINESS/INDUSTRY: UNKNOWN

17. FATHER'S NAME (First, Middle, Last): EMANUEL KERSH

18. MOTHER'S NAME (First, Middle, Maiden Surname): ETTA KRAKOWER

19a. INFORMANT'S NAME (Type/Print): ALAN KERSH

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2101 CHESTNUT ST., APT. 614 PHILADELPHIA, PA 19103

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ANSHE EMUNAH DATE: 3/30/92

20c. LOCATION — City or Town, State: BALTIMORE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jay Alan Levin

22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPIRATION PNEUMONIA — 1 WEEK

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CEREBROVASCULAR ACCIDENT

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GASTRO INTESTINAL BLEED

PARKINSONS DISEASE (END STAGE)

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MEDICAL RESIDENT

29c. LICENSE NUMBER: SINAI RESIDENT

29d. DATE SIGNED (Month, Day, Year): 03/28/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HUEH BODIE, MDCM, 6062 GREEN MEADOW PKWY, BALTIMORE MD 21209

31. DATE FILED (Month, Day, Year): APR 01 1992

32. REGISTRAR'S SIGNATURE: Joanna Davidson-Randall

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92 09121

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ivy E. Little (IVY E LITTLE)				2. DATE OF DEATH (Month / Day / Year): 3 / 31 / 92	3. TIME OF DEATH: 12:42 PM
4. SOCIAL SECURITY NUMBER: 216-32-0126	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9-17-27	8. BIRTHPLACE (State or Foreign Country): ENGLAND
9a. FACILITY NAME (If not institution, give street and number): GOOD SAMARITAN HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5011 Pilgrim RD		10f. ZIP CODE: 21214	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Person	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Joseph Richards		18. MOTHER'S NAME (First, Middle, Maiden Surname): Harriet (Not Known)	
19a. INFORMANT'S NAME (Type/Print): Clarence H. Little		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5011 Pilgrim Road Baltimore, Md. 21214	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cem. 4/3/92	DATE	20c. LOCATION — City or Town, State: Baltimore Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Milton J. Knight Jr		22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac Arrest 2° to Myocardial Infarction	45 min.
DUE TO (OR AS A CONSEQUENCE OF): b.	HTN	years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Hypercholesterolemia	years
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO Not accepted	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Susan G. Weiner MD	29c. LICENSE NUMBER: D34941	29d. DATE SIGNED (Month, Day, Year): ▶ 3-31-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SUSAN G. WEINER M.D 5601 LOCH RAVEN BLVD, BALTIMORE 21239		
31. DATE FILED (Month, Day, Year): APR 01 1992	32. REGISTRAR'S SIGNATURE: [illegible]	

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09122
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HYMAN M. LEVIN					2. DATE OF DEATH (Month, Day, Year): MAR. 29, 1992	3. TIME OF DEATH: 6:35 P. M
4. SOCIAL SECURITY NUMBER: 213-32-9465	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6/2/1912	8. BIRTHPLACE (State or Foreign Country): MASSACHUSETTS
9a. FACILITY NAME (If not institution, give street and number): 5814 HIGHGATE DR.			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5814 HIGHGATE DR.		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OFFICE SUPERVISOR	16b. KIND OF BUSINESS/INDUSTRY: POSTAL SERVICE
17. FATHER'S NAME (First, Middle, Last): JACOB LEVIN		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY LEVIN	
19a. INFORMANT'S NAME (Type/Print): MRS. MOLLIE LEVIN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5814 HIGHGATE DR. BALTIMORE, MD 21215	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HEBREW ORTHODOX MEM. SOC. DATE: 3/30/92	20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ellenore Levenson		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO,.MD 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Parkenson's Disease	10 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H. Ronald Friedman MD	29c. LICENSE NUMBER: D 01703	29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H Ronald Friedmen MD 23 Crossroads Dr. Owings Mills, Md 21117

31. DATE FILED (Month, Day, Year): APR 01 1992	32. REGISTRAR'S SIGNATURE: Trisha Davidson-Randall

DHMH-16 Rev 1/89

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92 09123

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DEBORAH L. LEE
2. DATE OF DEATH (Month / Day / Year): 03 / 25 / 92
3. TIME OF DEATH: 0905A M
4. SOCIAL SECURITY NUMBER: 219-70-0534
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 32 YRS.
   IF UNDER 1 YEAR: MONTHS / DAYS
   IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5/30/1959
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Harbor View Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1525 Caroline Street
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Negro
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disability
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Charles Leon Brook
18. MOTHER'S NAME (First, Middle, Maiden Surname): Shirley McIntosh
19a. INFORMANT'S NAME (Type/Print): Ted Kennedy Lee
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 819 Gilrubin Court Apt-8 Balto,Md. 21212
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans — DATE:
20c. LOCATION — City or Town, State: BAlto County,Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ
22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2222 W. North Ave, Balto, Md.21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → e.	SEPTIC SHOCK	1 DAY
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CARDIAC ARREST S/P CPR	6 HRS
DUE TO (OR AS A CONSEQUENCE OF):		
c.	VENTRICULAR FIBRILLATION	6 HRS
DUE TO (OR AS A CONSEQUENCE OF):		
d.	S/P MITRAL VALVE Replacement 2° to MR	1 1/2 YR

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RHEUMATIC HEART DISEASE.
HYPOXIC ENCEPHALOPATHY.
SEIZURE DISORDER

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] HOUSE STAFF
29c. LICENSE NUMBER: X5244161FJJ
29d. DATE SIGNED (Month, Day, Year): ▶ 3/25/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TITO MANORS TANGUILIG HARBOR HOSPITAL BALTO MD
31. DATE FILED (Month, Day, Year): APR 1 1992
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

Item4,15,Film686,4/3/92,1t

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09124

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): IOLA LEE			2. DATE OF DEATH (Month, Day, Year): 3-26-92	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-74-~~6663~~ 6603	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-05-04	8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): 2839 E. Federal Street		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md.		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore, City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO XX
10e. STREET AND NUMBER: 2839 E. Federal Street		10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed X 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO XX IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4Years	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): John D. Cole		18. MOTHER'S NAME (First, Middle, Maiden Surname): Liza Wiley	
19a. INFORMANT'S NAME (Type/Print): Audrey Wilson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2839 E. Federal St./ Baltimore, Md. 21213	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Mt. Calvary Cemetery DATE	20c. LOCATION — City or Town, State: Anne Arundel Co, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bernard D Johnson		22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic vascular disease	10yr
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Diabetes
Multiple Strokes

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: 033307	29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MAURA McGUIRE 1000 EAST LAGER STREET BALTO MD 21202

31. DATE FILED (Month, Day, Year): APR 0 1 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09125

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Michelle Vanessa Mitchell			2. DATE OF DEATH (Month / Day / Year): 03/28/92	3. TIME OF DEATH: 9:10 AM M
4. SOCIAL SECURITY NUMBER: 218-58-8599	5. SEX: 1 [ ] M 2 [X] F	6. AGE (In yrs. last birthday): 38 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 10/8/1953	8. BIRTHPLACE (State or Foreign Country): U.S.A.
8a. FACILITY NAME (If not institution, give street and number): Umms		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 601 LINNARD St.		10f. ZIP CODE: 21229	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Cornelius Marshall		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucille Harrington.	
19a. INFORMANT'S NAME (Type/Print): LUCILLE GROGAN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4003 W. FOREST PK. AVE BALTIMORE, MD21207	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK DATE	20c. LOCATION — City or Town, State: ARBUTUS, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett		22. NAME AND ADDRESS OF FACILITY: LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVE 21207	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Staphylococcus MRSA+ pneumoniae.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. HIV⊕ AIDS

DUE TO (OR AS A CONSEQUENCE OF):

c. PCP pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

d. Hypotension despite fluid resuscitation.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HIV⊕
H/o PCP pneumoniae

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Trevor A. Holmore MD	29c. LICENSE NUMBER: Umms	29d. DATE SIGNED (Month, Day, Year): 3/28/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Umms.		
31. DATE FILED (Month, Day, Year): APR 0 1 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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92 09126

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH L. MURPHY
2. DATE OF DEATH (Month, Day, Year): MARCH 27, 1992
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 244 03 1310
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): AUG. 6, 1903
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 10008 MAGLEDT ROAD
9b. CITY, TOWN OR LOCATION OF DEATH: LARNEY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: LARNEY
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 10008 MAGLEDT ROAD
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 YRS. — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRINTER
16b. KIND OF BUSINESS/INDUSTRY: HOME MUTAL LIFE INS.
17. FATHER'S NAME (First, Middle, Last): FRANK J. MURPHY
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA HOPKINS
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEMETERY — DATE:
20c. LOCATION — City or Town, State: PARKVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Anemia

DUE TO (OR AS A CONSEQUENCE OF):

c. Myelodysplasia (pre-Leukemia)

DUE TO (OR AS A CONSEQUENCE OF):

d. Osteoporosis

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
26d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28l. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. Nowakowski MD
29c. LICENSE NUMBER: D080916
29d. DATE SIGNED (Month, Day, Year): MARCH 27, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. ANDREW NOWAKOWSKI 125 NORTH MAIN STREET - BEL AIR

31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09127

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VERNON BRUCE MILLER
2. DATE OF DEATH: MONTH 03 DAY 30 YEAR 92
3. TIME OF DEATH: 4:30 P M
4. SOCIAL SECURITY NUMBER: 216-30-6538
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 57 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-5-34
8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): 2704 ERIE AVE
9b. CITY, TOWN OR LOCATION OF DEATH: CARNEY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: CARNEY
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2704 ERIE AVE
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TRAFFIC Engineering
16b. KIND OF BUSINESS/INDUSTRY: BALTIMORE County
17. FATHER'S NAME (First, Middle, Last): IRA Edgar MILLER
18. MOTHER'S NAME (First, Middle, Maiden Surname): KATHRYN R. WEBB
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code):
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Green MOUNT — DATE: 3/31/92
20c. LOCATION — City or Town, State: Baltimore, City
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert W. Greene
22. NAME AND ADDRESS OF FACILITY: EVANS Chapel of Memories 8600 Harford Rd, Baltimore, Md 21234

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastatic lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Craig M. Shaughnessy MD
29c. LICENSE NUMBER: D 39078
29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. Craig Shaughnessy 9512 Harford Rd. Baltimore, Md. 21234
31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

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92 09128

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna M. MANKOWSKI
2. DATE OF DEATH (Month, Day, Year): March 31 1992
3. TIME OF DEATH: 6:00 p M
4. SOCIAL SECURITY NUMBER: 120-14-7070
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 10, 1903
8. BIRTHPLACE (State or Foreign Country): QUEEN N.Y.
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSP.
9b. CITY, TOWN OR LOCATION OF DEATH: ROSEDALE
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTO. CO.
10c. CITY, TOWN OR LOCATION: CHASE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 4 JOGGINS COURT
10f. ZIP CODE: 21220
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5 +): —
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SHORT ORDER COOK
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): RICHARD VICK
18. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE SMITH
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): DULANEY VALLEY MEM
DATE: 4-2
20c. LOCATION — City or Town, State: COCKEYSVILLE MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffrey L. Fair
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8300 HARFORD RD. 21234

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Lung Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: (ATTENDING PHYS)
29c. LICENSE NUMBER: D29601
29d. DATE SIGNED (Month, Day, Year) ▶ 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): JOSEPH B KUGMAN, MD. 8701 HARFORD RD BALT. MD. 21234
31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09129
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CORINE E. McLARIN — CORRINE McLARIN
2. DATE OF DEATH (Month, Day, Year): 3 29 92
3. TIME OF DEATH: 645P M
4. SOCIAL SECURITY NUMBER: 220-01-3981
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 90 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7-8-01
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: GLEN BURNIE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 403 McLARIN DRIVE
10f. ZIP CODE: 21061
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): WILLIAM MACKEY
18. MOTHER'S NAME (First, Middle, Maiden Surname): REBECCA
19a. INFORMANT'S NAME (Type/Print): HELEN JOHNSON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 403 McLARIN DRIVE/GLEN BURNIE, MD 21060
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): ARBUTUS MEMORIAL PARK — DATE:
20c. LOCATION — City or Town, State: ARBUTUS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lynette L. Jones
22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E.NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. HEPATIC FAILURE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CONGESTIVE HEART FAILURE ATRIAL FIBRILLATION
DUE TO (OR AS A CONSEQUENCE OF):
c. SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Sher Afzal Hashmi MD
29c. LICENSE NUMBER: D24848
29d. DATE SIGNED (Month, Day, Year): ▶ 3-29-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SHER A HASHMI 2600 LIBERTY HEIGHTS AVE BALTIMORE 21215
31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

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92 09130

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RONALD W. MONGER			2. DATE OF DEATH: MONTH 3 DAY 31 YEAR 92	3. TIME OF DEATH: 2:25 a M
4. SOCIAL SECURITY NUMBER: 229-10-9701	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-12-07	8. BIRTHPLACE (State or Foreign Country): Tennessee
9a. FACILITY NAME (If not institution, give street and number): Meridian Cromwell		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Towson		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 951 Starbit Rd.		10f. ZIP CODE: Towson		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 yrs; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warehouse Foreman		16b. KIND OF BUSINESS/INDUSTRY: Goodyear Tire&Rubber Co.
17. FATHER'S NAME (First, Middle, Last): Samuel Monger			18. MOTHER'S NAME (First, Middle, Maiden Surname): Willie Eblan	
19a. INFORMANT'S NAME (Type/Print): Evelyn L. Monger		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 951 Starbit Rd. Towson, Md. 21204		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Memorial	DATE: 4-1	20c. LOCATION — City or Town, State: Finksburg, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory failure	immediate
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Tracheobronchitis	1 week
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Chronic aspiration	5 weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Cerebrovascular accident	5 weeks

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [✓] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Serena R Nolan MD	D25010	▶ 3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SERENA Sernea Nolan M.D. 8035 Harford Rd,

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 0 1 1992	Julia Davidson-Pondelle

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09131
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MICHAEL JOSEPH McNAMARA

2. DATE OF DEATH (Month, Day, Year): MARCH 31, 1992

3. TIME OF DEATH: 6:15 AM

4. SOCIAL SECURITY NUMBER: 216-36-8509

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 51 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): DEC. 24, 1940

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): 5549 ASHBOURNE ROAD

9b. CITY, TOWN OR LOCATION OF DEATH: ARBUTUS

9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: BALTIMORE

10c. CITY, TOWN OR LOCATION: ARBUTUS

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 5549 ASHBOURNE ROAD

10f. ZIP CODE: 21227

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: VIETNAM

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 4 YRS

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUPERVISOR-ANALYST

16b. KIND OF BUSINESS/INDUSTRY: SOCIAL SECURITY

17. FATHER'S NAME (First, Middle, Last): WILLIAM JOHN McNAMARA

18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN VIRGINIA CHAILLOU

19a. INFORMANT'S NAME (Type/Print): HELEN V. McNAMARA

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5549 ASHBOURNE ROAD-BALTIMORE, MD. 21227

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): NEW CATHEDERAL CEMETERY — DATE: 4/3

20c. LOCATION — City or Town, State: BALTIMORE

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M. Neal Coleman

22. NAME AND ADDRESS OF FACILITY: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Lung CA → brain metastasis — 9 mo
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Diana R. Feng M.D.

29c. LICENSE NUMBER: D39834

29d. DATE SIGNED (Month, Day, Year): 3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. DIANA FENG - 4660 WILKENS AVENUE - BALTIMORE, MARYLAND 21229

31. DATE FILED: APR 1 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09132
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH M. NICOLAUS

2. DATE OF DEATH (Month, Day, Year): March 27, 1992

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 212-07-3481

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 80 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 05-10-1911

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): 9101 Cuckold Road

9b. CITY, TOWN OR LOCATION OF DEATH: Edgemere

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: N/A

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 527 N. Washington Street

10f. ZIP CODE: 21205

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 8TH GRADE
College (1-4 or 5+): N/A

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Custodian

16b. KIND OF BUSINESS/INDUSTRY: Baltimore City

17. FATHER'S NAME (First, Middle, Last): James Nocar

18. MOTHER'S NAME (First, Middle, Maiden Surname): Teresa Komenda

19a. INFORMANT'S NAME (Type/Print): Mr. Albert Nocar, Jr.

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9101 Cuckold Road Baltimore, Md. 21219

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery — DATE: 3-30

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Chas W. Fish

22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Multiple Myeloma — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death: a. 6-12 mos

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Moodie Wynn M.D.

29c. LICENSE NUMBER: D0 7517

29d. DATE SIGNED (Month, Day, Year): ▶ 3/27/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 429 S Chester St 21231

31. DATE FILED (Month, Day, Year): APR 0 1 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

3

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09133
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary K. PILARSKI			2. DATE OF DEATH: MONTH March DAY 27, YEAR 1992	3. TIME OF DEATH: 10:07 A M
4. SOCIAL SECURITY NUMBER: 217-62-3993	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 40 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-1-1951	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Rossville		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Overlea/Fullerton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 33 Henry Avenue		10f. ZIP CODE: 21236	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Homemaking	
17. FATHER'S NAME (First, Middle, Last): Donald Dunstan Dellone, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Annetta Frances Gluth	
19a. INFORMANT'S NAME (Type/Print): Mr. Andrew J. Pilarski	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 Henry Avenue Baltimore, Maryland 21236		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard Allen	22. NAME AND ADDRESS OF FACILITY: Leasure F H 7401 Belair Rd Balto., Md. 21236		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Malignant Melanoma with Metastasis to lung,	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. brain, and liver.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: ☒ 1 Natural ☐ 2 Accident ☐ 3 Suicide ☐ 4 Homicide ☐ 5 Pending Investigation ☐ 6 Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Anne E Sugden MD.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Anne Sugden, MD 9000 Franklin SquareDrive Baltimore, MD 21237		
31. DATE FILED (Month, Day, Year): APR 01 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09134
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN PICKFORD JR				2. DATE OF DEATH (Month, Day, Year): 03 28 1992	3. TIME OF DEATH: 05:05 a M
4. SOCIAL SECURITY NUMBER: 217-01-3973	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 08-16-13	8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2868 GARRISON AVE.		10f. ZIP CODE: 21215		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: AFR. AMER.

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): JOHN PICKFORD SR.	18. MOTHER'S NAME (First, Middle, Maiden Surname): TAMA	
19a. INFORMANT'S NAME (Type/Print): SIVICIA HENSON 2868	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2868 GARRISON AVE. BALTIMORE, MARYLAND 21215	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): KING MEM. PARK DATE: 04-03-02	20c. LOCATION — City or Town, State: Randallstown, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Neil A. Estep	22. NAME AND ADDRESS OF FACILITY: ESTEP BROTHERS FUNERAL HOME 1300EUTAW PLACE BALTIMORE, MARYLAND 21217	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Sepsis	48 hours
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Aspiration Pneumonia	3 months
	DUE TO (OR AS A CONSEQUENCE OF): c. Meningioma Resection	1 year
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
N. Punjabi MD		3/28/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Naresh Punjabi 600 N. Wolfe Street Baltimore MD 21205

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 1 1992	Julia Davidson-Randall

DHMH-16 Rev 1/69

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

0-020-31-40 004 1

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92 09135

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harry Selby Purnell, Jr.
2. DATE OF DEATH: Month 3 Day 30 Year 92
3. TIME OF DEATH: 12 50 M
4. SOCIAL SECURITY NUMBER: 189-09-8419
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 87 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): March 30, 1992
8. BIRTHPLACE (State or Foreign Country): Philippines
9a. FACILITY NAME (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY
9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Worcester
10c. CITY, TOWN OR LOCATION: Ocean City
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 10417 Golf Course Road
10f. ZIP CODE: 21842
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): International Businessman
16b. KIND OF BUSINESS/INDUSTRY: International business
17. FATHER'S NAME (First, Middle, Last): Harry S. Purnell, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Kenly
19a. INFORMANT'S NAME (Type/Print): Reba M. Purnell
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10417 Golf Course, Ocean City, Md. 21842
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Paul's Episcopal Church | DATE: 4/1/92
20c. LOCATION — City or Town, State: Berlin, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ T. Kirk Burbage
22. NAME AND ADDRESS OF FACILITY: Burbage Funeral Home, 108 Williams St. Berlin, Md. 21811

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intestinal bowel — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
28. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M D Horner MD
29c. LICENSE NUMBER: D 19053
29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Wm. B. Horner MD
31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: Julia Lander Kendall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09136

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be sent within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Roth — John F. Roth
2. DATE OF DEATH: MONTH 3 DAY 30 YEAR 92
3. TIME OF DEATH: 8:30 PM
4. SOCIAL SECURITY NUMBER: 057016590
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS — DAYS — IF UNDER 24 HRS.: HOURS — MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/27/06
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6201 Loch Raven Blvd.
10f. ZIP CODE: 21239
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Hotel Manager
16b. KIND OF BUSINESS/INDUSTRY: Hilton Hotel's
17. FATHER'S NAME (First, Middle, Last): Charles Roth
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Stoyer
19a. INFORMANT'S NAME (Type/Print): Alfred Roth
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 32 Bowers, Pennsylvania 19511
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Elmwood Cemetery — DATE: 4/2/92
20c. LOCATION — City or Town, State: Yale, Michigan
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark T. Zavoyna — ▶ Mark T. Zavoyna
22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Md. 21214

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hepatic encephalopathy 2° Hepatic Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. possible Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
c. Upper GI bleed.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Marwan Tabbara M.D.
29c. LICENSE NUMBER: —
29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARWAN TABBARA, Good Samaritan Hospital
31. DATE FILED (Month, Day, Year): 3/30/92
32. REGISTRAR'S SIGNATURE: APR 01 1992 — [illegible]

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09137

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MINNIE RANKIN

2. DATE OF DEATH Month: 3 Day: 30 Year: 92

3. TIME OF DEATH: 1:00A M

4. SOCIAL SECURITY NUMBER: 212-18-2727

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 81 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): NOV. 26, 1910

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: BALTIMORE

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10a. STREET AND NUMBER: 12 STONEHENGE CIRCLE

10f. ZIP CODE: 21208

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES XX

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puarto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify: X

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEOENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECRETARY-BOOKKEEPER

16b. KIND OF BUSINESS/INDUSTRY: FOOD

17. FATHER'S NAME (First, Middle, Last): JACOB MICHAEL

18. MOTHER'S NAME (First, Middle, Maiden Surname): DEVORAH BABKOV

19a. INFORMANT'S NAME (Type/Print): MRS. BARBARA ROMBRO

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7719 GRASTY RD. BALTO., MD 21208

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): HEBREW YOUNG MEN — DATE: 3/31/92

20c. LOCATION — City or Town, State: BALTIMORE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sol Levinson

22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. MASSIVE MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. SEVERE CORONARY ARTERY DISEASE

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: anupa Khastgir MD

29c. LICENSE NUMBER: D40946

29d. DATE SIGNED (Month, Day, Year): 3/30/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANUPA KHASTGIR, SINAI HOSPITAL

31. DATE FILED (Month, Day, Year): APR 01 1992

32. REGISTRAR'S SIGNATURE: Grace Davidson-Randall

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12

Item20b 4-2-92 FilmG686 W.H. Per F/H

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09138 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JACQUELINE PIERCE REID			2. DATE OF DEATH: MONTH 3 DAY 29 YEAR 92	3. TIME OF DEATH: 2:20 PM M
4. SOCIAL SECURITY NUMBER: 418-66-0598	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 2-8-46	8. BIRTHPLACE (State or Foreign Country): ALABAMA
9a. FACILITY NAME (If not institution, give street and number): 4207 PIMLICO ROAD (RES.)		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4207 PIMLICO ROAD		10f. ZIP CODE: 21215		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): THOMAS PIERCE			18. MOTHER'S NAME (First, Middle, Maiden Surname): EULA MAE MITCHELL	
19a. INFORMANT'S NAME (Type/Print): ROBERT REID		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4207 PIMLICO ROAD BALTIMORE, MD 21215		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. cemetery, crematory or other place): King Memorial Park LOUDON PARK CEMETERY	DATE	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O Dyett		22. NAME AND ADDRESS OF FACILITY: LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BREAST CANCER — DUE TO (OR AS A CONSEQUENCE OF): — 5 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. — DUE TO (OR AS A CONSEQUENCE OF):

c. — DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BONE METASTASES, RENAL FAILURE
SKIN METASTASES
HYPERCALCEMIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D35606	29d. DATE SIGNED (Month, Day, Year): 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAMUEL ZYGLER 4000 old Court Rd, Baltimore, MD 21208		
31. DATE FILED (Month, Day, Year): APR 01 1992		

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3

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09139

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mabel (nee Lane) Ramsburg
2. DATE OF DEATH (Month, Day, Year): March 27, 1992
3. TIME OF DEATH: 1500 M
4. SOCIAL SECURITY NUMBER: 218-42-1717
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): December 8, 1913
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Manor Care, Ruxton
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore Co.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore Co.
10c. CITY, TOWN OR LOCATION: Towson
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 919 Dulaney Valley Ct., Apt. #2
10f. ZIP CODE: 21204
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Homemaker
17. FATHER'S NAME (First, Middle, Last): Sewell F. Lane
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena A. Phillips
19a. INFORMANT'S NAME (Type/Print): Donald C. Ramsburg
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2509 Meredith Road, White Hall, Maryland
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Memorial Park
20c. LOCATION — City or Town, State: Sykesville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul T. Lochstampfor M00849
22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Road, Timonium, MD. 21093

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARCINOMA of LUNG.	?
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A.H. Ghiladi MD.
29c. LICENSE NUMBER: D-12849
29d. DATE SIGNED (Month, Day, Year): 3-29-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.H. GHILADI, M.D. 7600 OSLER Dr. TOWSON MD 21204
31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

92 09140

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IF THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IF THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Regina Magdelan Reynolds
2. DATE OF DEATH (Month, Day, Year): March 26 1992
3. TIME OF DEATH: 10 AM
4. SOCIAL SECURITY NUMBER: 219-34-7005
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 96 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 29 1895
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not Institution, give street and number): Manor Care Nursing Home - Ruxton
9b. CITY, TOWN OR LOCATION OF DEATH: Ruxton
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Cockeysville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 219 Wickersham Way
10f. ZIP CODE: 21030
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Homemaker
17. FATHER'S NAME (First, Middle, Last): Thomas F. Hanley
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Bothwell
19a. INFORMANT'S NAME (Type/Print): Regina Schulz
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 219 Wickersham Way, Cockeysville, Md. 21030
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens
20c. LOCATION — City or Town, State: Timonium, Md. 21093
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul T. Lochstampfor — Paul T. Lochstampfor M00849
22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd., Timonium, Md. 21093

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the dasth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. Liet only one cause on eech line.

IMMEDIATE CAUSE (Final diseese or condition resulting in death) → a. Congestive Heart failure — Approximate interval Between Onset and Death: Years

DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Diseeae or injury that initiated events resulting in death) LAST

b. due To CORONARY ARTERY

DUE TO (OR AS A CONSEQUENCE OF):

c. DISEASE due To Atherosclerosis

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A.H. Chaldin MD
29c. LICENSE NUMBER: D-12849
29d. DATE SIGNED (Month, Day, Year): 3-26-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.H. CHALDI, M.D. 7600 OSLER Dr. Towson, Md 21204
31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09141

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louise Randolph				2. DATE OF DEATH (Month, Day, Year): March 28, 1992	3. TIME OF DEATH: 9:39 P M
4. SOCIAL SECURITY NUMBER: 220-14-4148	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5/15/1925	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1539 Mountmor Court		10f. ZIP CODE: 21217	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Negro

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Benjamin Blake	18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Wright
19a. INFORMANT'S NAME (Type/Print): Robert Leon Blake	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2407 Loyola Northway Apt-203 BAlto,Md. 21215

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cemetery	DATE	20c. LOCATION — City or Town, State: Balto County, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ	22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2222 W. North Ave Balto, Md. 21216		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary Artery Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H. Farhat M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): March 28, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H. Farhat, M.D. c/o Maryland General Hospital

31. DATE FILED (Month, Day, Year): APR 1 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09142 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hugh Sell
2. DATE OF DEATH (Month, Day, Year): 3-28-1992
3. TIME OF DEATH: 1919 M
4. SOCIAL SECURITY NUMBER: 212-03-0507
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 04-11-19
8. BIRTHPLACE (State or Foreign Country): Unknown
9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md.
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balto.
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1217 Fayette St.
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+)
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): unemployed
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Unknown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown
19a. INFORMANT'S NAME (Type/Print):
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code):
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Lion Cem. DATE 3/30
20c. LOCATION — City or Town, State: Balto.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Betts Funeral Home
22. NAME AND ADDRESS OF FACILITY: 1123 N. Caroline St

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septic shock

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

aspiration pneumonia
adult respiratory failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D16263
29d. DATE SIGNED (Month, Day, Year) ▶ 3/30/91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JUAN A. PEITRAN, 1940 W. BALT. ST, BALT, MD 21223

31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09143

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dennis Robert Skelton
2. DATE OF DEATH: Month March, Day 26, Year 92
3. TIME OF DEATH: 6:20 P M
4. SOCIAL SECURITY NUMBER: 217-38-9589
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 50 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6-13-1941
8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: ROSSVILLE
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: DUNDALK
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7721 FAIRGREEN ROAD
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 YEARS; College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): IRON WORKER
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): JOSEPH LAWRENCE SKELTON
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE FRANCES ANKROM
19a. INFORMANT'S NAME (Type/Print): JO LYNN SKELTON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7721 FAIRGREEN ROAD BALTIMORE, MARYLAND 21222
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH CEM. DATE 3/31/92
20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastic Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year):
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Theodore Stephens M.D. 9000 Franklin Square Drive Baltimore, Md. 21237
31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: [signature]

DHMN-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09144 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE RUSSELL SIPES
2. DATE OF DEATH: MONTH 3 DAY 27 YEAR 92
3. TIME OF DEATH: 2:27A M
4. SOCIAL SECURITY NUMBER: 219-12-2028
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 66 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-13-1925
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: DUNDALK
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [X] NO
10e. STREET AND NUMBER: 2803 WEST WOODWELL ROAD
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: KOREA
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11TH GRADE; College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BREWERY WORKER
16b. KIND OF BUSINESS/INDUSTRY: CARLING NATIONAL BREWERY
17. FATHER'S NAME (First, Middle, Last): WILLIAM SIPES
18. MOTHER'S NAME (First, Middle, Maiden Surname): GLADYS NANCY GREENE
19a. INFORMANT'S NAME (Type/Print): ANNA B. SIPES
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2803 WEST WOODWELL ROAD BALTIMORE, MARYLAND 21222
20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE: BEL AIR MEMORIAL 3-30-1992
20c. LOCATION — City or Town, State: BEL AIR, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Chas W Fisher
22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
lung cancer, prostate CA, skin cancer, pheochromocytoma

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26i. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James P. Campion MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 3/27/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4940 Eastern Avenue Baltimore MD 21209
31. DATE FILED (Month, Day, Year): APR 01 1992
32. REGISTRAR'S SIGNATURE: Gina Davidson Randall

DHMH-16 Rev 1/89

6+1

92 09145

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE LINDSEY STURGEON
2. DATE OF DEATH: MONTH 3 DAY 31 YEAR 92
3. TIME OF DEATH: 1:45 PM
4. SOCIAL SECURITY NUMBER: 212-16-5039
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): JAN. 6, 1921
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? [X] YES [ ] NO
10e. STREET AND NUMBER: 302 WILLOW AVENUE
10f. ZIP CODE: 21206
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CARPENTER
16b. KIND OF BUSINESS/INDUSTRY: BUILDING COMPANY
17. FATHER'S NAME (First, Middle, Last): GEORGE FREDERICK STURGEON
18. MOTHER'S NAME (First, Middle, Maiden Surname): CARRIE B. BOONE
19a. INFORMANT'S NAME (Type/Print): MARY E. MYERS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 236-ROCK HALL , MD. 21661
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY — DATE: 4/2
20c. LOCATION — City or Town, State: BALTIMORE
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dawn L. Fisher
22. NAME AND ADDRESS OF FACILITY: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Resident
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. Moscoud St Agnes Hospital
31. DATE FILED (Month, Day, Year): APR 1 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

571

92 09146

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BEULAH H. SILVERMAN			2. DATE OF DEATH (Month, Day, Year): March 28, 1992	3. TIME OF DEATH: 10:30 P M
4. SOCIAL SECURITY NUMBER: 579 60 0998	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Mar. 14, 1902	8. BIRTHPLACE (State or Foreign Country): Washington DC
9a. FACILITY NAME (If not institution, give street and number): Hebrew Home of Greater Washington		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville	9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 6121 Montrose Road		10f. ZIP CODE: 20852	10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY: Veteran's Administration		
17. FATHER'S NAME (First, Middle, Last): Nisan Hess		18. MOTHER'S NAME (First, Middle, Maiden Surname): (unascertainable)		
19a. INFORMANT'S NAME (Type/Print): Rita S. Cook		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5200 Partridge Lane, Washington, D. C. 20016		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Washington Hebrew Congregation Memorial Park	20c. LOCATION — City or Town, State: Washington, D. C.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald C. Stottlemyer		22. NAME AND ADDRESS OF FACILITY: STEIN HEBREW MEMORIAL FUNERAL HOME, Inc. 232 CARROLL STREET, N. W., WASHINGTON, D.C.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio pulmonary arrest DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Bronchiogenic Carcinoma DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

arteriosclerotic heart disease. Hypertension. Diabetes mellitus. Congestive heart failure. Organic brain syndrome. COPD

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date end piece, end due to the cause(e) and manner se stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER: D17191	29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Barrett Lewis Burka, M. D., 4607 Connecticut Avenue, N. W. Washington, D. C. 20008

31. DATE FILED (Month, Day, Year): APR 01 1992	32. REGISTRAR'S SIGNATURE: [signature]

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09147
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George W. Wood Jr.				2. DATE OF DEATH (Month, Day, Year): 03 31 92	3. TIME OF DEATH: 9:15 AM
4. SOCIAL SECURITY NUMBER: 217-05-6241	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan 17 1920	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3603 Southern Avenue		10f. ZIP CODE: 21214	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tavern Owner - Self	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): George W. Wood Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Estelle Frank	
19a. INFORMANT'S NAME (Type/Print): Emily S. Wood		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3603 Southern Avenue Baltimore, Md. 21214	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial DATE: 4/3/92	20c. LOCATION — City or Town, State: Baltimore Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Milton J Knight Jr. Milton J. Knight Jr.		22. NAME AND ADDRESS OF FACILITY: Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Road	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia with Bronchiolitis Obliterans DUE TO (OR AS A CONSEQUENCE OF):	3 wks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF):	
	c. Pulmonary Emboli DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H Lababidi, M.D.	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year): 3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Hani Lababidi, GOOD SAMARITAN HOSP.

31. DATE FILED (Month, Day, Year): APR 01 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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b

92 09148

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN KENNARD WILHELM, SR.		2. DATE OF DEATH (Month, Day, Year): 03 27 92	3. TIME OF DEATH: 11:37 PM
4. SOCIAL SECURITY NUMBER: 213-05-8110	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4-27-1910
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): CHARLOTTE HALL V.A.M.C.	9b. CITY, TOWN OR LOCATION OF DEATH: CHARLOTTE HALL	9c. COUNTY OF DEATH: ST. MARY	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: ESSEX	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1000 FRANKLIN AVENUE	10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OIL BURNER TECHNICIAN	16b. KIND OF BUSINESS/INDUSTRY: OIL	
17. FATHER'S NAME (First, Middle, Last): HERBERT I. WILHELM	18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA PAINTER		
19a. INFORMANT'S NAME (Type/Print): ALICE V. CARTER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7931 CHARLESMONT ROAD BALTIMORE, MARYLAND 21222		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH CEMETERY 3/30	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Chas W. Fahl	22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Ischemia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): APR 0 1 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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92 09149

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): Joseph A m White Jr.

2. DATE OF DEATH Month: 3 Day: 27 Year: 92

3. TIME OF DEATH: 507 P M

4. SOCIAL SECURITY NUMBER: 216502369

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 44 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 05/02/48

8. BIRTHPLACE (State or Foreign Country): Baltimore

9a. FACILITY NAME (If not institution, give street and number): Loch Raven VA Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore MD

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 2412 Seabury Road

10f. ZIP CODE:

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: Vietnam

13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: Black

15. OECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Welder

16b. KIND OF BUSINESS/INDUSTRY: Unemployed

17. FATHER'S NAME (First, Middle, Last): Joseph Allen White Sr.

18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Lee Campbell White

19a. INFORMANT'S NAME (Type/Print): =Barbara White

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4813 Williston Rd. Balti. Md. 21229

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Garrison Forest — DATE: 4/2

20c. LOCATION — City or Town, State: Baltimore, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Eugene R. Price

22. NAME AND ADDRESS OF FACILITY: Eugene R. Price Funeral Home
108 W. North Ave. Balti. Md. 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Esophageal Varices	36 hours
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hepatic cirrhosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO — will be

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Scott A Feeser

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 3/27/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Scott A. Feeser, Loch Raven VA Hosp, Baltimore MD

31. DATE FILED (Month, Day, Year): APR 0 1 1992

32. REGISTRAR'S SIGNATURE: Julia Berdon Kemp

DHMH-16 Rev 1/89

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9-149-19-07 002
WILLIAMS JEANNE
4/10/1947 W F
100 1608

92 09150

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JEANNE WILLIAMS
2. DATE OF DEATH (Month, Day, Year): 03 29 1992
3. TIME OF DEATH: 11:00 PM
4. SOCIAL SECURITY NUMBER: 216-48-4053
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 44 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 5-10-1947
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6725 Yataruba Drive
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Systems Analyst
16b. KIND OF BUSINESS/INDUSTRY: Computer Industry
17. FATHER'S NAME (First, Middle, Last): Bernard Waitsman
18. MOTHER'S NAME (First, Middle, Maiden Surname): Genevieve Waitsman
19a. INFORMANT'S NAME (Type/Print): Richard Williams
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6725 Yataruba Drive Balto., Md. 21207
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory Inc. DATE: 4-1-92
20c. LOCATION — City or Town, State: Catonsville Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Derrick C. Jones
22. NAME AND ADDRESS OF FACILITY: Derrick C. Jones F.H. 4611 Park Heights Ave. Balto., Md.15

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO BE COMPLETED BY THE MEDICAL EXAMINER OR CORONER DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be completed by the medical examiner within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	SEPSIS	1 WEEK
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	LYMPHOMA	2.5yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: RENAL INSUFFICIENCY

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURRED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MC MD RESIDENT PHYSICIAN
29c. LICENSE NUMBER: J2070
29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID P. MCCAMMON, 600 N. WOLFE. ST, BALTO. MD 21212
31. DATE FILED (Month, Day, Year): APR 0 1 1992
32. REGISTRAR'S SIGNATURE: Jeha Davidson-Rondell

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92 09151

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Virginia A. West			2. DATE OF DEATH (Month, Day, Year): March 29 1992	3. TIME OF DEATH: 11:50 P M
4. SOCIAL SECURITY NUMBER: 220-12-5641	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 7 1911	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Manor Care - Ruxton		9b. CITY, TOWN OR LOCATION OF DEATH: Ruxton	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Timonium	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2422 Chetwood Circle		10f. ZIP CODE: 21093	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Homemaker

17. FATHER'S NAME (First, Middle, Last): William Agee	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel O'Dell
19a. INFORMANT'S NAME (Type/Print): Virginia C. O'Brien	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2428 Chetwood Circle, Timonium, Md. 21093

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory	DATE	20c. LOCATION — City or Town, State: Catonsville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bryan W. Clary		22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md. 21093	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet ceused the death. Do not enter the mode of dying, such ea cerdiec or reapiratory arrest, ahock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Acute Renal Failure. — 9

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. due to ATHEROSCLEROSIS.

OUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. H. Ghiladi	29c. LICENSE NUMBER: D-12849	29d. DATE SIGNED (Month, Day, Year): 3-30-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. H. Ghiladi, M.D. 7600 Osler Dr., Suite 111, Towson, Md.

31. DATE FILED (Month, Day, Year): APR 0 1 1992	32. REGISTRAR'S SIGNATURE: Jacqueline Davidson-Randall

DHMH-18 Rev 1/89

1 DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09152
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rubetha Webb			2. DATE OF DEATH (Month, Day, Year): 3-28-92	3. TIME OF DEATH: 10:50 A.M
4. SOCIAL SECURITY NUMBER: 217-22-0554	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 86 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 2-16-06	8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): 1049 N. Caroline St.		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: —
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: —	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2623 N. Aisquith St.		10f. ZIP CODE: 21218		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress		16b. KIND OF BUSINESS/INDUSTRY: Factory
17. FATHER'S NAME (First, Middle, Last): David Jones			18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebecca Smith	
19a. INFORMANT'S NAME (Type/Print): Catherine Thompson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7201 Seymour Pl. Balto, Md.		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem. Park 4-2-92		20c. LOCATION — City or Town, State: Arbutus, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randolph J. Collick		22. NAME AND ADDRESS OF FACILITY: Collick F.H. 2431 E. Oliver St.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Leukemia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	M		

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] M.D.	008358	3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gracito V. Patricio, M.D.P.A
703 S. Clinton Street, Baltimore, Md. 21224

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 1 1992	[signature]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09153
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANTHONY THURSTON YORK				2. DATE OF DEATH: MONTH 3 DAY 30 YEAR 92	3. TIME OF DEATH: 9:30 p M
4. SOCIAL SECURITY NUMBER: 048-58-3567	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 29 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 18, 1962	8. BIRTHPLACE (State or Foreign Country): Tennessee
9a. FACILITY NAME (If not institution, give street and number): 3300 Whitesworth Rd.				9b. CITY, TOWN OR LOCATION OF DEATH: Phoenix	9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Phoenix	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3300 Whitesworth Road		10f. ZIP CODE: 21131	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Band Director	16b. KIND OF BUSINESS/INDUSTRY: Fallston High School
17. FATHER'S NAME (First, Middle, Last): Gordon S. York		18. MOTHER'S NAME (First, Middle, Maiden Surname): Janice Meyers	
19a. INFORMANT'S NAME (Type/Print): Mrs Victoria H. York		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Sane As #10	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Belair Memorial Gardens DATE 4-2-92	20c. LOCATION — City or Town, State: Belair, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Melanoma	21 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ian K. Slepian MD	29c. LICENSE NUMBER: D33231	29d. DATE SIGNED (Month, Day, Year): 03/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Ian Slepian Galleria Health Center York Rd. and Seminary Ave

31. DATE FILED (Month, Day, Year): APR 0 1 1992	32. REGISTRAR'S SIGNATURE: Lidia Davidson-Randall

DHMH-16 Rev 1/89

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92 09154

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louis A. Anderson			2. DATE OF DEATH (Month, Day, Year): 3 28 1992	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-07-8608	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-27-1915	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2611 Ambler Rd.		9b. CITY, TOWN OR LOCATION OF DEATH: Dundalk-Gray Manor		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Dundalk		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2611 Ambler Rd.,		10f. ZIP CODE: 21222		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [✓] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHite
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steel Worker		16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel
17. FATHER'S NAME (First, Middle, Last): Alexander Anderson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Martell		
19a. INFORMANT'S NAME (Type/Print): Helen M. Anderson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2611 Ambler Rd., Dundalk, Md. 21222		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Oak Lawn Cemetery DATE: 3-31-92		20c. LOCATION — City or Town, State: Balto.,Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Phillip Hanks M00550		22. NAME AND ADDRESS OF FACILITY: Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd.,Dundalk,Md. 21222		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Malignancy Probably from Pancreas. DUE TO (OR AS A CONSEQUENCE OF):	11 m.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Congestive Heart Failure, and A.S.C.V.D. DUE TO (OR AS A CONSEQUENCE OF):	
	c. atrial fibrillation DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Lung Cancer and Rt. Pneumonectomy

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. OESCRIBE HOW INJURY OCCUREO		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ataollah Golpira, MD.	29c. LICENSE NUMBER: D02191	29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): ATAOLLAH GOLPIRA 3029 Dundalk ave. Balto, Md. 21222

31. DATE FILED (Month, Day, Year): APR 0 2 1992	32. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09155

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN BEACH (JOHN BEACH)
2. DATE OF DEATH: MONTH 3 DAY 27 YEAR 92
3. TIME OF DEATH: 1045 PM
4. SOCIAL SECURITY NUMBER: 220 09 9648
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2 12 1912
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): Univ. Maryland at Baltimore UMMS
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore MD
9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel Co
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 1132 Dicus Mill road
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY?
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last)
18. MOTHER'S NAME (First, Middle, Maiden Surname)
19a. INFORMANT'S NAME (Type/Print)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) in state
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) / DATE
20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir — ▶ Joseph B. Van Hart
22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD 655 WBaltimoreSt, Balto., MD 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac and respiratory arrest due to respiratory insufficiency	few minutes
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Comatose State due to massive Stroke	1/24/92
DUE TO (OR AS A CONSEQUENCE OF): c.	massive stroke with bilateral pneumonia	1/24/92
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
bilateral lower lobe pneumonia
Myocardial infarction

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Dr. Richard Sonnenheimer MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 3/27/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SONNENHEIMER MICHAEL MD UMMS 22 S. Greene St. Balto MD 21228
31. DATE FILED (Month, Day, Year): APR 2 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

92 09156

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Theadore Bailey, Jr
2. DATE OF DEATH (Month, Day, Year): 3 26 92
3. TIME OF DEATH: 8 00 P M
4. SOCIAL SECURITY NUMBER: 217-58-9208
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 37 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 4, 1954
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1934 East 31st Street
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. OECEDENT'S EOUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): James T. Bailey, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Genevieve Lingham
19a. INFORMANT'S NAME (Type/Print): Marilyn B. Bailey
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6825 Bonnie Ridge Dr. Apt T2 Balto MD 21209
20a. METHOD OF OISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, crematory or other place): Western Star Cemetery — DATE: 3/31
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest R. Ennis Jr.
22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes Inc 2501 Gwynns Falls Parkway Baltimore, MD 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. AIDS	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneumonia	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] ODA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF OEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. OESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Brian Lee MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 3/26/92
30. NAME AND AOORESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print): Brian Lee Union Memorial Hospital
31. DATE FILED (Month, Day, Year): APR 02 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall BALTO Md 21218

DHMH-16 Rev 1/89

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

92 09157

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Maggie VIOLA Brown				2. DATE OF DEATH (Month, Day, Year): 4 1 1992	3. TIME OF DEATH: 6:20 AM
4. SOCIAL SECURITY NUMBER: 223-10-8213-D	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6-28-1913	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): Pleasant Manor Nursing Center			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4615 PARK HEIGHTS AVENUE		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: USA.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): SIMON STEVENS	18. MOTHER'S NAME (First, Middle, Maiden Surname)		
19a. INFORMANT'S NAME (Type/Print): CRISZON BROWN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4618 MAINFIELD AVENUE, BALTIMORE, MD. 21214		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. CALVARY CEMETERY	20c. LOCATION — City or Town, State: GLEN BURNIE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charlene D. Brown	22. NAME AND ADDRESS OF FACILITY: JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST. BALTO. MD. 21223; P.O. BOX 4433		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Myocardial Infarction	5 min
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Arteriosclerotic cardiovascular disease	5 yrs.
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetes Mellitus
Hypertension
History of Congestive Heart Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jaime Punzalan MD	29c. LICENSE NUMBER: D15124	29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jaime Punzalan, M.D. 5214 Harford Rd., Baltimore, MD 21214

31. DATE FILED (Month, Day, Year): APR 2 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

92 09158

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES H BACH		2. DATE OF DEATH (Month, Day, Year): 03 31 1992	3. TIME OF DEATH: 2:05PM M
4. SOCIAL SECURITY NUMBER: 213-07-7481	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 08/23/1911
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): G.B.M.C., 6701 N. CHARLES STREET	9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT			
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 81 WEBER AVENUE	10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Pipe Fitter	16b. KIND OF BUSINESS/INDUSTRY: Steel Mill	
17. FATHER'S NAME (First, Middle, Last): Charles H. Bach Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Henline		
19a. INFORMANT'S NAME (Type/Print): Agnes Bach, Wife	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 81 Weber Ave. Baltimore, MD 21221		
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery	DATE: 4/3/92	20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Eastern Ave. Baltimore, MD 21221		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. COMPLETE HEART BLOCK AND C.H.F.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. MYOCARDIAL INFARCTION	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. A.S.H.D., AND HYPERTENSION	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M
	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): APR 02 1992	32. REGISTRAR'S SIGNATURE	

DHMH-16 Rev 1/89

92 09159

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gladys A. Brandhagen. GLADYS A. BRANDHAGEN			2. DATE OF DEATH: MONTH 03 DAY 31 YEAR 92	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-04-3765	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): 01-01-1907	8. BIRTHPLACE (State or Foreign Country): NORTH DAKOTA
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1202 EUTAWPLACE	10f. ZIP CODE: 21217		10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MINISTER	16b. KIND OF BUSINESS/INDUSTRY: CHURCH

17. FATHER'S NAME (First, Middle, Last): ALBERT BRANDHAGEN	18. MOTHER'S NAME (First, Middle, Maiden Surname): EDITH BRANDHAGEN
19a. INFORMANT'S NAME (Type/Print): BISHOP BETTY MIDDLETON	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1202 EUTAW PLACE BALTIMORE, MARYLAND 21217

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): FERNCLIFF CEMETERY	DATE: 04-06-92	20c. LOCATION — City or Town, State: HARTSDALE, NEW YORK
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lloyd M Estep	22. NAME AND ADDRESS OF FACILITY: ESTEP BROTHERS FUNERAL HOME 1300 EUTAW PLACE Baltimore, Maryland 21217		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure.	one week
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Renal Failure.	one week
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Lamothe MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario R. Lamothe		
31. DATE FILED (Month, Day, Year): APR 02 1992	32. REGISTRAR'S SIGNATURE: Gina [illegible]	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09160 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Olen NMN Burkett			2. DATE OF DEATH (Month, Day, Year): March 31 1992	3. TIME OF DEATH: 8:P.M
4. SOCIAL SECURITY NUMBER: 236-28-6295	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 05 20 1924	8. BIRTHPLACE (State or Foreign Country): W. Virginia
9a. FACILITY NAME (If not institution, give street and number): Bushy St. 6431			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: Bushy St. 6431		10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Aug43 -Dec 43	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: x	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mail Handler	16b. KIND OF BUSINESS/INDUSTRY: Poastal Service	
17. FATHER'S NAME (First, Middle, Last): John NMN Burkett		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie NMN Miller	
19a. INFORMANT'S NAME (Type/Print): Delores Burkett	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Bushy St. 6431 Baltimore, Md. 21224		
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn	DATE: 4-3	20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark A Chojnacki	22. NAME AND ADDRESS OF FACILITY: W.Dabrowski-Chojnacki Funeral Chapel P.A. 1005 Dundalk Ave. Balto., Md.21224		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pancreatic cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D36951	29d. DATE SIGNED (Month, Day, Year): 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): APR 02 1992	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

5+1

92 09161

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GERARD C. BERTHOLD			2. DATE OF DEATH (Month, Day, Year): MARCH 31, 1992	3. TIME OF DEATH: 2:25 PM M
4. SOCIAL SECURITY NUMBER: 335-14-4874	5. SEX: X M 2 ☐ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 01-16-10	8. BIRTHPLACE (State or Foreign Country): Illinois
9a. FACILITY NAME (If not institution, give street and number): LORIEN NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA		9c. COUNTY OF DEATH: HOWARD

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 9461 Dunloggin Road		10f. ZIP CODE: 21042	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade - 10; College (1-4 or 5+):	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Special Service Banker	16b. KIND OF BUSINESS/INDUSTRY: Banking	
17. FATHER'S NAME (First, Middle, Last): George Berthold		16. MOTHER'S NAME (First, Middle, Maiden Surname): Maude Copeland	
19a. INFORMANT'S NAME (Type/Print): Mary F. Berthold (WIFE)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9461 Dunloggin Road, Ellicott City, MD 21042	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory Inc. DATE: 04/01/92	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: LEROY M. RUSSELL C. WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. LYMPHOMA - RECURRENT	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ATHEROSCLEROTIC VASCULAR DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CONGESTIVE HEART FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. STROKE	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Emergent 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: MD 25210	29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JERRY E. SEALS, 3460 ELLICOTT CENTER DRIVE, ELLICOTT CITY, MD. 21043		
31. DATE FILED (Month, Day, Year): APR 02 1992	32. REGISTRAR'S SIGNATURE: [signature] Lia Davidson-Randall	

DHMH-16 Rev 1/89

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92 09162

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lula V. Clinedinst					2. DATE OF DEATH (Month, Day, Year): 3 - 30 - 92	3. TIME OF DEATH: 9:45 P M
4. SOCIAL SECURITY NUMBER: 214-14-9638	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 1 - 21-1900	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Villa St. Michaels			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: ----------	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: -------	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4800 Seton Drive Villa St. Michaels		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): John Lockner		18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Appleby	
19a. INFORMANT'S NAME (Type/Print): Mr. Carl Clinedinst	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Swann Keys, Box E14 Selbyville, Delaware 19975		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Lorraine Park Cemetery	DATE: 4/2	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Tracy Henss Carpenter	22. NAME AND ADDRESS OF FACILITY: Burgee-Henss Funeral Home 3631 Falls Road Baltimore, Maryland 21211		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	Minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Meshulam MD.	29c. LICENSE NUMBER: D38675	29d. DATE SIGNED (Month, Day, Year): ▶4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Meshulam 2360 W. Joppa Road		
31. DATE FILED (Month, Day, Year): APR 2 1992	32. REGISTRAR'S SIGNATURE: Jutha Davidson-Randall	

DHMH-16 Rev 1/89

92 09163

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARVEY LEWIS CHALMERS

2. DATE OF DEATH (Month, Day, Year): March 28 1992

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 225-14-7100

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 71 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Jun 14 1920

8. BIRTHPLACE (State or Foreign Country): Virginia

9a. FACILITY NAME (If not institution, give street and number): 546 McMechen Street

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS?: 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 546 McMechen Street

10f. ZIP CODE: 21217

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: Dec 42 - Nov 45

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [ ] NO Specify:

14. RACE — American Indian, Black, White, etc.: Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th Grade
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bus Driver

16b. KIND OF BUSINESS/INDUSTRY: Mass Transit Administra

17. FATHER'S NAME (First, Middle, Last): Willie Chalmers

18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary

19a. INFORMANT'S NAME (Type/Print): Mary L. Chalmers

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 546 McMechen St. Baltimore, MD 21217

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Mem Park — DATE: 4/4

20c. LOCATION — City or Town, State: Elkridge, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest R. Ennis Jr.

22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes Inc
2501 Gwynns Falls Parkway
Baltimore, MD 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Bronchiogenic Carcinoma

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Metastatic Lesions to Liver

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None

24a. WAS AN AUTOPSY PERFORMED?: 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?: 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?: 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY: M

28c. INJURY AT WORK?: 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael M Hunt MD

29c. LICENSE NUMBER: D-13619

29d. DATE SIGNED (Month, Day, Year): 3.31.92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 2300 Madison Blvd Balt. MD 2121[illegible]

31. DATE FILED (Month, Day, Year): APR 02 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

5+1

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09164 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alberta Crafton			2. DATE OF DEATH (Month, Day, Year): April 1, 1992	3. TIME OF DEATH: 10:20am M
4. SOCIAL SECURITY NUMBER: 239-01-5544	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5 16 18	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2594 Druid Park Drive		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maid	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): unk.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Williams	
19a. INFORMANT'S NAME (Type/Print): Maxine Crafton	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2594 Druid Lake Drive Baltimore, Maryland 21215		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial Park DATE: 4/6/92	20c. LOCATION — City or Town, State: Randallstown, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leroy Harris	22. NAME AND ADDRESS OF FACILITY: Leroy Harris F/H 638 N. Gilmor St. Baltimore, Md 21217		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Electro-mechanical dissociation	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Congestive heart failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Right pleural effusion	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Fever; diarrhea

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: T. Kocsis	29c. LICENSE NUMBER: n/a	29d. DATE SIGNED (Month, Day, Year): ▶ 4/01/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Tamas Kocsis, M.D. c/o Maryland General Hospital

31. DATE FILED (Month, Day, Year): APR 0 2 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09165

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ABBIE Cockey Abbie L. Cockey
2. DATE OF DEATH: MONTH 3 DAY 28 YEAR 92
3. TIME OF DEATH: 1:15 A M
4. SOCIAL SECURITY NUMBER: 271-12-6704
5. SEX: 1 ☐ M 2 ☒ F
6. BIRTHPLACE (State or Foreign Country): Georgia
7. DATE OF BIRTH (Month, Day, Year): 11 17 07
8. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3903 Fairfax Road
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Frank Copeland
18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Knight
19a. INFORMANT'S NAME (Type/Print): Michele Cockey
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3903 Fairfax Road Baltimore, Maryland 21216
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cemetery — DATE: 4/1/92
20c. LOCATION — City or Town, State: Catonsville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leroy Harris
22. NAME AND ADDRESS OF FACILITY: Leroy Harris F/H 638 N. Gilmor St. Baltimore, Md 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. SEVERE ANEMIA

DUE TO (OR AS A CONSEQUENCE OF): PNEUMONIA / SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF): METASTATIC BREAST CANCER

c. DUE TO (OR AS A CONSEQUENCE OF): Myocardial Infarction

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Terance D. Lamb MD
29c. LICENSE NUMBER: D31203
29d. DATE SIGNED (Month, Day, Year): ▶ 3 28 92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TERANCE LAMB LIBERTY MEDICAL CENTER Baltimore md.

31. DATE FILED (Month, Day, Year): APR 0 2 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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items 23 Part I,27,28a,b,c,d,e,f, per MEO, G-686, 4/17/92 gn

92-1783-005

92 09166

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): STEVEN W. CACHOLA
2. DATE OF DEATH (Month, Day, Year): 03 27 1992
3. TIME OF DEATH: 1:35 PM
4. SOCIAL SECURITY NUMBER: 219-66-9942
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 35 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 10/01/1956
8. BIRTHPLACE (State or Foreign Country): Baltimore Md.
9a. FACILITY NAME (If not institution, give street and number): 3003 Dundalk Ave.
9b. CITY, TOWN OR LOCATION OF DEATH: Dundalk
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Dundalk
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3003 Dundalk Ave.
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): some
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Designer
16b. KIND OF BUSINESS/INDUSTRY: Farm Mech.
17. FATHER'S NAME (First, Middle, Last): William V. Cachola
18. MOTHER'S NAME (First, Middle, Maiden Surname): Gladys Walton
19a. INFORMANT'S NAME (Type/Print): Jimmy Cachola
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1520 Ridge Rd. Whiteford, Md. 21160
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus DATE 3/31/92
20c. LOCATION — City or Town, State: Dundalk, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Phillip Hart M00550
22. NAME AND ADDRESS OF FACILITY: Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd. Dundalk, Md. 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Doxepin intoxication

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): Found 3/27/92
28b. TIME OF INJURY: Found 1:20P M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: Subject ingested doxepin
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Found: home
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Found: 3003 Dundalk Ave. Balto., MD 21222

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. Dixon
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): 03-28-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. DIXON 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year): APR 02 1992
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

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92 09167

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician for attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANDREW V. CURRERI				2. DATE OF DEATH (Month, Day, Year): March 31, 1992	3. TIME OF DEATH: 8:25 P. M
4. SOCIAL SECURITY NUMBER: 216-40-1052	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 50 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 21, 1942	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1320 Sherwood Ave.			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10a. STREET AND NUMBER: 1320 Sherwood Ave.		10f. ZIP CODE: 21239	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Army Nat. Guard	13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman - Dulaney Valley Memorial Gardens	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Carmelo Curreri		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Curreri	
19a. INFORMANT'S NAME (Type/Print): Mrs Judy C. Curreri		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gards.	DATE: 4-3-92	20c. LOCATION — City or Town, State: Timonium, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks Jr.		22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Small cell Ca of lung
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John H. Eppler	29c. LICENSE NUMBER: D26002	29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John H,.Eppler, M. D. 120 Sister Pierre Dr. Towson, Md. 21204

31. DATE FILED (Month, Day, Year): APR 0 2 1992	32. REGISTRAR'S SIGNATURE: [illegible] Davidson-Randall

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELSIE CAROLINE EVANS
ELSIE C. EVANS

2. DATE OF DEATH (Month, Day, Year): 3/9/92

3. TIME OF DEATH: 5:30 A. M

4. SOCIAL SECURITY NUMBER: 215-10-1594

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 83 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 8-01-1908

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): The Wesley Home, Inc.

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH: na

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: na

10c. CITY, TOWN OR LOCATION: 2211 W. Rogers Ave.

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER: 2211 W. Rogers Ave.

10f. ZIP CODE: 21209

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☐ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+):

16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerical

16b. KIND OF BUSINESS/INDUSTRY: Insurance Co

17. FATHER'S NAME (First, Middle, Last): Frederick Evans

18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie KNipp

19a. INFORMANT'S NAME (Type/Print): Jeffery Evans

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 Andrew Hill Ct, Arnold, MD 21012

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):

20c. LOCATION — City or Town, State:

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir
Joseph B. Wade 4/1/92

22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD
655W BaltimoreST, Balto., MD 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE PULMONARY EDEMA — ACUTE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CONGESTIVE CARDIOMYOPATHY — 2 MONTHS
DUE TO (OR AS A CONSEQUENCE OF):
c. CORONARY ARTERY DISEASE — YEARS
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): N/A

28b. TIME OF INJURY: — M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED: —

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): —

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): —

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert E. Roby MD

29c. LICENSE NUMBER: D-19425

29d. DATE SIGNED (Month, Day, Year): 3/9/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT E. ROBY, M.D. - 2211 W. ROGERS AVE 21209

31. DATE FILED (Month, Day, Year): APR 2 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

92 09169

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ida C. Fowlkes
2. DATE OF DEATH (Month, Day, Year): 3 27 92
3. TIME OF DEATH: 15:15 M
4. SOCIAL SECURITY NUMBER: 220-07-8083
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 04/18/20
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Catonsville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2 Summitt Hill Ct., Unit A2
10f. ZIP CODE: 21228
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 7 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Developer
16b. KIND OF BUSINESS/INDUSTRY: CGR Medical Systems
17. FATHER'S NAME (First, Middle, Last): Augustine LeBlanc
18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche LaMontagna
19a. INFORMANT'S NAME (Type/Print): Eldon Lawson Fowlkes
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Summitt Hill Ct., Unit A2, Catonsville, Md. 21228
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park — DATE: 3/31
20c. LOCATION — City or Town, State: Elkridge, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L. Kaufman
22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Home, 5695 Main St., Elkridge, Md. 21227

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not anter ths mode of dying, such ss cardiac or respiratory srrest, shock, or hasrt failure. List only one cause on aech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumonitis	<12h
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Vasculitis	2mo
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i.: Diabetes Mellitus; COPD; CHF, Hypothyroidism

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at tha time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Javier Calderon, M.D.
29c. LICENSE NUMBER: 54H
29d. DATE SIGNED (Month, Day, Year): ▶ 3/27/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Javier Calderon 900 Caton Ave.
31. DATE FILED (Month, Day, Year): APR 0 2 1992

DHMH-16 Rev 1/89

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GOLDER PATRICIA
07/07/92 [illegible]
21215 F [illegible]

92-09170

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PATRICIA GOLDER
2. DATE OF DEATH (Month, Day, Year): 03 31 1992
3. TIME OF DEATH: 9.45 AM
4. SOCIAL SECURITY NUMBER: 213 54 2393
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 42 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/10/49
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Balto., Md.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2803 Virginia Avenue
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES XX
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary
16b. KIND OF BUSINESS/INDUSTRY: Balto. City Housing
17. FATHER'S NAME (First, Middle, Last): Roy Washington
18. MOTHER'S NAME (First, Middle, Maiden Surname): Johnnie Mae Glover
19a. INFORMANT'S NAME (Type/Print): Catherine Washington
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2803 Virginia Ave. Balto.,Md 21215
20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus DATE: 4/4/
20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton
22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
b. LUNG CANCER WITH METASTASES
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Sekyema PGY I
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year):
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): YAO-FOLI SEKYEMA
31. DATE FILED (Month, Day, Year): 3/APR 07 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

92 09171

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RONALD HENLY
2. DATE OF DEATH: MONTH 3 DAY 28 YEAR 92
3. TIME OF DEATH: 10 15 P M
4. SOCIAL SECURITY NUMBER: 217-68-4483
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 36 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-31-1955
8. BIRTHPLACE (State or Foreign Country): BALTIMORE, MD.
9a. FACILITY NAME (If not institution, give street and number): SETON HILL MANOR NH
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2904 ALLENDALE ROAD
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY?: USA.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEOENT'S EOUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+):
16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED
18b. KINO OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): PHILLIP ROANE
18. MOTHER'S NAME (First, Middle, Meiden Surneme): EDNA HENLY
19a. INFORMANT'S NAME (Type/Print): ANGELA HENLY
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 515 CALHOUN STREET, BALTIMORE, MD. 21223
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY — DATE: 4-2-92
20c. LOCATION — City or Town, State: CATONSVILLE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph H. Brown Jr.
22. NAME AND ADDRESS OF FACILITY: JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST. BALTO. MD. 21223; P.O. BOX 4433

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such aa cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Chronic renal failure	Months
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST — b.	AIDS	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
OUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF OEATH (Check only one) — HOSPITAL: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF OEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. OATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end dua to the ceuse(s) end manner aa stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and pieca, and dua to the ceuse(s) end menner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Michael A. Hayes, MD
29c. LICENSE NUMBER: D 02290
29d. DATE SIGNEO (Month, Day, Year): 3/28/92
30. NAME ANO AODRESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): APR 2 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09172

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SALLIE L HANCOCK
2. DATE OF DEATH (Month, Day, Year): 4 / 1 / 92
3. TIME OF DEATH: 10:00 AM
4. SOCIAL SECURITY NUMBER: 230-20-6882
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 65 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)
7. DATE OF BIRTH (Month, Day, Year): 5-29-26
8. BIRTHPLACE (State or Foreign Country): USA Va.
9a. FACILITY NAME (If not institution, give street and number): BONSECOURS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE MD
9c. COUNTY OF DEATH: CITY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: CITY
10c. CITY, TOWN OR LOCATION: BALTIMORE MD
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: COMMUNITY CARE NURSING HOME
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: B
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook
16b. KIND OF BUSINESS/INDUSTRY: Carr-Lowery Glass
17. FATHER'S NAME (First, Middle, Last): Carson E. Stevens
18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Watkins
19a. INFORMANT'S NAME (Type/Print): Sharon Pledger
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1511 Ramblewood Rd. Balto., Md. 21239
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star
20c. LOCATION — City or Town, State: 4/4 Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton
22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens St. Balto.,Md. 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic Carcinoma of the Lung

DUE TO (OR AS A CONSEQUENCE OF): b. Acute obstructive pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. H/O Strokes

DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death:

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETIDN DF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Physician
29c. LICENSE NUMBER: D29269
29d. DATE SIGNED (Month, Day, Year): 4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Marcelino D. Albuerne 516 N. Rolling Rd Bn Ho
31. DATE FILED (Month, Day, Year): APR 02 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09173
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Melvin August Horst Sr.
2. DATE OF DEATH: MONTH 3 DAY 31 YEAR 92
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-30-5174
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 59 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-11-32
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 7935 Dalrose Ave.
9b. CITY, TOWN OR LOCATION OF DEATH: Rosedale
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Rosedale
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7935 Dalrose Ave.
10f. ZIP CODE: 21237
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5 +) /
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Superintendent
16b. KIND OF BUSINESS/INDUSTRY: Charles H. Harper Inc.
17. FATHER'S NAME (First, Middle, Last): Henry Horst
18. MOTHER'S NAME (First, Middle, Maiden Surname): Alma Engelke
19a. INFORMANT'S NAME (Type/Print): Mary S. Horst
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7935 Dalrose Ave. Baltimore, MD 21237
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill's DATE 4-3-92
20c. LOCATION — City or Town, State: Middle River, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Denis S. Kelly
22. NAME AND ADDRESS OF FACILITY: Cvach/rosedale funeral Home 1211 chesaco ave.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SQUAMOUS CELL CA TONSIL
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
BONE METASTASES
HYPERCALCEMIA

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): 2112 BELAIR RD ABINGTON, MD 21047 Suite 4a
31. DATE FILED (Month, Day, Year): APR 2 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09174

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Susanna M. Handschumacher/A/K/A Anna M. & Ann M.		2. DATE OF DEATH (Month, Day, Year): 3/28/92	3. TIME OF DEATH: 2:45 A M
4. SOCIAL SECURITY NUMBER: 232-26-9656	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/8/1899
8. BIRTHPLACE (State or Foreign Country): W. Va.			
9a. FACILITY NAME (If not Institution, give street and number): Greater Laurel Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Laurel	9c. COUNTY OF DEATH: Prince George's	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Elkridge	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5930 Setter Drive	10f. ZIP CODE: 21227	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): John J. Morris	18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah J. (Last name unobtainable)		
19a. INFORMANT'S NAME (Type/Print): Jackie Andrea	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5930 Setter Drive, Elkridge, Md. 21227		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery	20c. LOCATION — City or Town, State: Arlington, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary L. Kaufman	22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Home 5695 Main St., Elkridge, Md. 21227		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetions that caused the death. Do not antar the mode of dying, such as cerdiac or reapiretory arreat, shock, or heert failure. Liet only one cauaa on each line.

Approximete interval Batween Onset and Death

IMMEDIATE CAUSE (Finel disesse or condition reeulting in death) →
a. Acute Cardio - Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Sepsis Pneumonia

Sequentielly liat conditione, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initiated events reeulting in death) LAST
c. Vulvar Carcinoma w/ metastatic
DUE TO (OR AS A CONSEQUENCE OF):
d. spread

PART II. Other significent conditions contributing to death but not reeulting in the underlying csuse given in Part I.
H/o Treatment Univ of Tenn Dept
H/o Cerebro Vascular Accident

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Villamor S. Reyes MD	29c. LICENSE NUMBER: D29671	29d. DATE SIGNED (Month, Day, Year): 3/28/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V. RAMON S. REYES, MD 6501 Landover Rd Cheverly MD 20785		
31. DATE FILED (Month, Day, Year): APR 0 2 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George L. Helinski		2. DATE OF DEATH (Month, Day, Year): April 1, 1992	3. TIME OF DEATH: 11:00 AM
4. SOCIAL SECURITY NUMBER: 212-09-2945	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 1,1907
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Cherrywood Manor Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Reisterstown, Maryland	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Reisterstown	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 321 Norgulf Road	10f. ZIP CODE: 21136	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Newspaper Distributor	16b. KIND OF BUSINESS/INDUSTRY: Newspaper	
17. FATHER'S NAME (First, Middle, Last): Joseph Helinski	18. MOTHER'S NAME (First, Middle, Maiden Surname): Julianna Sobus		
19a. INFORMANT'S NAME (Type/Print): Bernadette Starr	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 321 Norgulf Road, Reisterstown, Maryland 21136		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St.Stanislaus Cemetery 4/4	20c. LOCATION — City or Town, State: Baltimore,Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond A Weber (Pres.) George A. Weber & Sons Inc.	22. NAME AND ADDRESS OF FACILITY: George A. Weber & Sons Inc. 705 S. Ann Street,Baltimore,Md.21231		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastic Prostate Cancer	Yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D27034	29d. DATE SIGNED (Month, Day, Year): 4/2/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ira Copeland M.D. 5310 Old Court Road, ~~Pikesville~~ Randallstown, Maryland 21133		
31. DATE FILED (Month, Day, Year): APR 0 2 1992	32. REGISTRAR'S SIGNATURE: Lina Davidson-Randall	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GERALD CRAIG JOHNSON
2. DATE OF DEATH (Month, Day, Year): 03 29 1992
3. TIME OF DEATH: 9:00 A.M.
4. SOCIAL SECURITY NUMBER: 214-66-2736
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 36 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7. DATE OF BIRTH (Month, Day, Year): Aug 30 1955
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 832 E. COLDSPRING LANE
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 832 East Coldspring Lane
10f. ZIP CODE: 21212
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): College 1
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance Work
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Norman E. Johnson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Armstead
19a. INFORMANT'S NAME (Type/Print): Lillian L. Alexander
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 832 E. Coldspring Lane Balto., MD 21212
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Arbutus memorial Park — DATE: 4/2
20c. LOCATION — City or Town, State: Baltimore Co, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes Inc, 2501 Gwynns Falls Parkway, Baltimore, MD 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HANGING

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [XX] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [XX] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 03-29-1992
28b. TIME OF INJURY:
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: SUBJECT HANGED SELF
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): AT HOME
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 832 E. COLDSPRING LANE

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): ▶ 03-29-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. M. DIXON, 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year): APR 0 2 1992
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

92 09177

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 may be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Lamar Jones			2. DATE OF DEATH (Month, Day, Year): 4/1/92	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 214-56-5094	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 42 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 3/25/50	8. BIRTHPLACE (State or Foreign Country): Ga.
9a. FACILITY NAME (If not institution, give street and number): 1209 Gleneagle Rd.		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1209 Gleneagle Rd.		10f. ZIP CODE: 21239	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager	16b. KIND OF BUSINESS/INDUSTRY: USF&G
17. FATHER'S NAME (First, Middle, Last): William Jones, Jr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mamie Bowman Humber	
19a. INFORMANT'S NAME (Type/Print): Nick L. Harris		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6720 Curran Rd. New Orleans, La. 70126	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn	20c. LOCATION — City or Town, State: Balto, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton		22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARDIOPULMONARY ARREST	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	ACQUIRED IMMUNE DEFICIENCY SYNDROME	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	HIV CARDIOMYOPATHY	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cytomegalovirus Retinitis with blindness

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D37299	29d. DATE SIGNED (Month, Day, Year): 4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CARLOS PAGE, MD 101 W. READ ST. / SUITE 815, BALT, MD 21201		
31. DATE FILED (Month, Day, Year): APR 02 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL, DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bertha R Lewis
2. DATE OF DEATH (Month, Day, Year): March 31 1992
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 216-12-3191
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 13 1905
8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): 1213 Wicklow Road
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1213 Wicklow Road
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): House Wife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Ned Washington
18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Addison
19a. INFORMANT'S NAME (Type/Print): Rosie Williams
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1213 Wicklow Road Baltimore, MD 21229
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) / DATE
20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vernon R. Bailey
22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes Inc, 2501 Gwynns Falls Parkway, Baltimore, MD 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Stroke
DUE TO (OR AS A CONSEQUENCE OF):
b. Diabetes
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number; City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Walter Koppal
29c. LICENSE NUMBER: D15538
29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WALTER KOPPAL 1900 E. NORTHERN PARKWAY

31. DATE FILED (Month, Day, Year): APR 02 1992
32. REGISTRAR'S SIGNATURE: Sylvia Davidson-Randall

DHMH-16 Rev 1/89

0-068-50-82 001 A
LEE MARIE J
5/05/1936 B F

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09179

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARIE J. LEE			2. DATE OF DEATH: MONTH MARCH DAY 31 YEAR 1992	3. TIME OF DEATH: 10:36 P M
4. SOCIAL SECURITY NUMBER: 215-34-7285	5. SEX: 1 ☐ M 2 XX F	6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-5-36	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 1230 MAPLELEAF COURT		10f. ZIP CODE: 21202	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABLED	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): CHARLES DESMOND		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE E. CHAMBERS	
19a. INFORMANT'S NAME (Type/Print): MARIE E. JEFFRESS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1029 McDONALD STREET/BALTIMORE, MD 21205	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY	DATE:	20c. LOCATION — City or Town, State: CATONSVILLE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald Hartle		22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Herpes Pneumonitis	4 wks
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Renal failure - Hemodialysis	4 wks
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Systemic Lupus	1 yr.
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Restrictive Cardiomyopathy	1 yr.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hemo @ Stool

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: W. Collins	29c. LICENSE NUMBER: E9814	29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Johns Hopkins Hospital Baltimore, MD

31. DATE FILED (Month, Day, Year): APR 02 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Hendricks

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09180
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BENJAMIN LIGHTNER			2. DATE OF DEATH (Month, Day, Year): 03 27 1992	3. TIME OF DEATH: 4:00 aM
4. SOCIAL SECURITY NUMBER: 247-22-7323	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4-7-17	8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 336 E. 22nd STREET		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABLED	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): M. CYE LIGHTNER		18. MOTHER'S NAME (First, Middle, Maiden Surname): JANIE	
19a. INFORMANT'S NAME (Type/Print): WILLIE BELLE LIGHTNER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 336 E. 22nd STREET/BALTIMORE, MD 21218	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): KING MEMORIAL PARK	DATE:	20c. LOCATION — City or Town, State: RANDALLSTOWN, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leonard Gaither		22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia (acute)	< 1 wk
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic M. Kansasii pneumonia	2 mo.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Chronic aspiration	2 mo.
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. anoxic brain damage	> 2 mo.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
NIDDM + gastroparesis; Chronic demyelinating inflammatory poly neuropathy

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charlotte M. McKee, MD	29c. LICENSE NUMBER: JB091	29d. DATE SIGNED (Month, Day, Year) ▶ 3/27/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHNS HOPKINS HOSP., 600 NO. WOLFE ST. TOWER 110, BALT. MD 21205		
31. DATE FILED (Month, Day, Year): APR 0 2 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kordella	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09181
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Fannie A. Lewis
2. DATE OF DEATH (Month, Day, Year): 3-30-92
3. TIME OF DEATH:
4. SOCIAL SECURITY NUMBER: 217-38-6608
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 10-12-39
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 1230 W. Pratt Street
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore, City
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1230 W. Pratt Street
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABLED
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): THEODORE R. BANKS
18. MOTHER'S NAME (First, Middle, Maiden Surname): JOANNA LEWIS
19a. INFORMANT'S NAME (Type/Print): PEARL JORDAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1230 W. PRATT STREET/BALTIMORE, MD 21223
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): KING MEMORIAL PARK — DATE:
20c. LOCATION — City or Town, State: RANDALLSTOWN, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Norman Gantt
22. NAME AND ADDRESS OF FACILITY: Wm.C. March F/H 1101 E. North Ave.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cardiec or respiratory errest, ehock, or heart feiiure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → e. PANCREATIC CARCINOMA — 1 MONTH

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

OUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
HYPERTENSION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY:
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Nathan A Scott, M.D.
29c. LICENSE NUMBER: D34484
29d. DATE SIGNED (Month, Day, Year): 3-31-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NATHAN A. SCOTT, M.D. 1000 E. EAGER ST BALTIMORE, MD 21202
31. DATE FILED (Month, Day, Year): APR 0 2 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Gonzalez

OHMH-16 Rev 1/89

IF THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
IF THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Item20b 4-10-92 FilmG686 W.H. Per F/H

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09182 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE T MASSEY JR

2. DATE OF DEATH: MONTH 3 DAY 31 YEAR 92

3. TIME OF DEATH: 9 25 P M

4. SOCIAL SECURITY NUMBER: 246-56-0960

5. SEX: 1 ☑ M 2 ☐ F

6. AGE (In yrs. last birthday): 53 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 1-26-39

8. BIRTHPLACE (State or Foreign Country): N.C.

9a. FACILITY NAME (If not institution, give street and number): HARBOR HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 2365 SEAMON AVENUE

10f. ZIP CODE: 21225

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.):

16b. KIND OF BUSINESS/INDUSTRY: W.R. GRACE

17. FATHER'S NAME (First, Middle, Last): GEORGE I. MASSEY

18. MOTHER'S NAME (First, Middle, Maiden Surname): CORA BECKAM

19a. INFORMANT'S NAME (Type/Print): ANNETTE MASSEY

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2365 SEAMON AVE./BALTIMORE, MD 21225

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Cemetery: Evergreen Memorial Cem PIEDMONT CEMETERY

20c. DATE

20c. LOCATION — City or Town, State: WINSTON SALEM, N.C.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Wendell Gallion

22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. METASTATIC BRONCOGENIC CARCINOMA OF THE LUNG — 2 YEARS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. UPPER GASTROINTESTINAL BLEEDING — 4 DAYS.

DUE TO (OR AS A CONSEQUENCE OF):
c. RENAL FAILURE — ?

DUE TO (OR AS A CONSEQUENCE OF):
d. PNEUMONIA — 4 DAYS.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D.

29c. LICENSE NUMBER: D41323

29d. DATE SIGNED (Month, Day, Year): 3-31-92.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANIEL H. ROSLER HHC.

31. DATE FILED (Month, Day, Year): APR 02 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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7/19/1956 2 F
1001991140

92 09183

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THELMA B. MILLER			2. DATE OF DEATH (Month, Day, Year): APRIL 1, 1992	3. TIME OF DEATH: 2:52A M
4. SOCIAL SECURITY NUMBER: 215-76-3346	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 35 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-19-56	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH: BALTIMORE CITY	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 733 MELLO COURT		10f. ZIP CODE: 21205	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY: BALTIMORE CITY PUBLIC SCHOOLS
17. FATHER'S NAME (First, Middle, Last): FRED I. VENEY		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH MOORE
19a. INFORMANT'S NAME (Type/Print): ROCKY B. MILLER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 733 MELLO COURT/BALTIMORE, MD 21205	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY — DATE:	20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard Gallion	22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Probable Pericardial Tamponade	2 hrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. TTP (5000 platelets) Thrombotic Thrombocytopenia	1 wk
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Autoimmune disease	1 yr.
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: TTP → Renal insf, hemolysis, hemorrhagic stroke

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] M.D.	29c. LICENSE NUMBER: E9814	29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Johns Hopkins Hospital Baltimore, Maryland		
31. DATE FILED (Month, Day, Year): APR 02 1992	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall	

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09184
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) HARRIETT LOUISE MULLANEY / HARRIETT LOUISE MULLANEY		2. DATE OF DEATH Month: 04 Day: 01 Year: 92	3. TIME OF DEATH 2:50 p M
4. SOCIAL SECURITY NUMBER 214-12-9173	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 72 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year) 02-09-20
8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) SAINT Joseph Hospital	9b. CITY, TOWN OR LOCATION OF DEATH TOWSON	9c. COUNTY OF DEATH Baltimore	

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Towson	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER 3 Southerly Ct.		10f. ZIP CODE 21204	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales	16b. KIND OF BUSINESS/INDUSTRY Ruben Donnelly Advertising Co.	
17. FATHER'S NAME (First, Middle, Last) Stanley Gardiner		18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Gosling	
19a. INFORMANT'S NAME (Type/Print) Gregory Mullaney	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10719 Pot Spring Rd., Cockeysville, Md. 21030		
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery DATE 4/4/92	20c. LOCATION — City or Town, State Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Randel C. Ritchie Jr	22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Metastatic Adenocarcinoma Lung	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hepatic metastasis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Beatrix P. Dizon M.D.	29c. LICENSE NUMBER D16492	29d. DATE SIGNED (Month, Day, Year) ▶ 4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BEATRIZ P. DIZON St. Joseph Hospital Towson Md.		
31. DATE FILED (Month, Day, Year) APR 02 1992	32. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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92-1607-005

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09185

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT DUANE McCOY

2. DATE OF DEATH: MONTH 03 DAY 19 YEAR 1992

3. TIME OF DEATH: 11:30 A.M

4. SOCIAL SECURITY NUMBER: 218-26-4745

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 61 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Nov. 17, 1930

8. BIRTHPLACE (State or Foreign Country): Pennsylvania

9a. FACILITY NAME (If not institution, give street and number): 6 DALMANEY COURT

9b. CITY, TOWN OR LOCATION OF DEATH: Parkville

9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Parkville

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 6 Dalmeny Court, Apt. 202

10f. ZIP CODE: 21234

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: Korea

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter

16b. KIND OF BUSINESS/INDUSTRY: Self employed

17. FATHER'S NAME (First, Middle, Last): Ivan William McCoy

18. MOTHER'S NAME (First, Middle, Maiden Surname): Romayne B. Smith

19a. INFORMANT'S NAME (Type/Print): Mrs. Mary E. Whitt

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1433 Philadelphia Rd., Aberdeen, Md. 21001

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Hilltop Service Corp. DATE 4/1/92

20c. LOCATION — City or Town, State: Towson, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Wm Meyer

22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave., Balto., Md. 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, ahock, or heart failure. List only ona cause on aech lina.

Approximata interval Between Onset and Death

IMMEDIATE CAUSE (Finei disease or condition resulting in death) →
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D.

29c. LICENSE NUMBER: O.C.M.E.

29d. DATE SIGNED (Month, Day, Year): ▶03-20-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARIO F. GOLLE JR., MD 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year): APR 02 1992

32. REGISTRAR'S SIGNATURE: [illegible]

DHMH-16 Rev 1/89

6+1

92 09186

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LA COUNTESS MATTHEWS		2. DATE OF DEATH (Month, Day, Year): 3/30/92	3. TIME OF DEATH: 0743 M
4. SOCIAL SECURITY NUMBER: 220-20-2993	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/1/28
8. BIRTHPLACE (State or Foreign Country): NEW YORKCITY			
9a. FACILITY NAME (If not institution, give street and number): STUART HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: BALTO.	10c. CITY, TOWN OR LOCATION: BALTO.	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6626 VINCENT LANE	10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): ?		18. MOTHER'S NAME (First, Middle, Maiden Surname): ?	
19a. INFORMANT'S NAME (Type/Print): GORDON PERKINS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6626 VINCENT LANE BALTIMORE, MD 21215	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY DATE	20c. LOCATION — City or Town, State: CATONSONVILLE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett		22. NAME AND ADDRESS OF FACILITY: LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARDIAC ARREST	Sudden
DUE TO (OR AS A CONSEQUENCE OF): b.	coronary artery disease	2/1/92
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	HAS CVD.	2/1/92
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Frederick C Malkus	29c. LICENSE NUMBER: D0 7000	29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): 3635 Old Court Rd, Baltimore, Md 21208		
31. DATE FILED (Month, Day, Year): APR 2 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau	

DHMH-16 Rev 1/89

92 09187

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNE JOHNSTON PARKER
2. DATE OF DEATH (Month, Day, Year): 3/26/1992
3. TIME OF DEATH: 10:30A M
4. SOCIAL SECURITY NUMBER: 580 05 7828
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-18-1905
8. BIRTHPLACE (State or Foreign Country): Florida
9a. FACILITY NAME (If not institution, give street and number): 11630 Glen Arm Road Apt G21
9b. CITY, TOWN OR LOCATION OF DEATH: Glen Arm
9c. COUNTY OF DEATH: Baltimore county

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore county
10c. CITY, TOWN OR LOCATION: Glen Arm
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 11630 Glen Arm Road Apt G21
10f. ZIP CODE: 21057
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KINO OF BUSINESS/INDUSTRY: Homemaker/rancher
17. FATHER'S NAME (First, Middle, Last): Roy Johnston
18. MOTHER'S NAME (First, Middle, Maiden Surneme): Anita Wakem Johnston
19a. INFORMANT'S NAME (Type/Print): Anne P. Karkow
19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 35 Running Fox Road, Glen Arm, MD 21057
20a. METHOO OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☒ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, crematory or other place)
OATE
20c. LOCATION — City or Town, Stata
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir — Joseph B. Kerkhoff — 4/2/92
22. NAME AND AODRESS OF FACILITY: STATE ANATOMY BOARD 655 W.BaltimoreSt,Balto.,MD 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. megaloblastic anemia — DUE TO (OR AS A CONSEOUENCE OF): — years.

Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evanta resulting in death) LAST

b. DUE TO (OR AS A CONSEOUENCE OF):

c. DUE TO (OR AS A CONSEOUENCE OF):

d.

PART II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, straat, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To tha best of my knowledge, death occurred at tha time, data and place, and dua to the cause(s) and manner es stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: B Rosenberg MD
29c. LICENSE NUMBER: D24121
29d. DATE SIGNED (Month, Day, Year): 3/31/92

30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. BRUCE ROSENBERG 1134 York Road, Lutherville, 21093

31. DATE FILED (Month, Day, Year): APR 2 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Ryder

DHMH-16 Rev 1/89

92 09188

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNETTE PERRY			2. DATE OF DEATH (Month, Day, Year): 3 28 92	3. TIME OF DEATH: 5:10 A M
4. SOCIAL SECURITY NUMBER: 213327204	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Apr 26 1936	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 504 Orchard Street		10f. ZIP CODE: 21201	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+):	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housekeeper	16b. KIND OF BUSINESS/INDUSTRY: Omni Intern'l Hotel	
17. FATHER'S NAME (First, Middle, Last): Frank El Fuller		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Ruth	
19a. INFORMANT'S NAME (Type/Print): George C. Perry	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 504 Orchard St. Baltimore, MD 21201		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest VA Cem	DATE: 4/3	20c. LOCATION — City or Town, State: Owings Mills, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest R. Perry Jr.	22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, MD 21216		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Small Cell Lung Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATN (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATN: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 3 28 92	28b. TIME OF INJURY: 5:10 A M
	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Harrison MD	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year): 3/28/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Harrison MD 22. S. Greene St. Baltimore, MD. 21201

31. DATE FILED (Month, Day, Year): APR 02 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09189

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MICHAEL PRITCHETT
2. DATE OF DEATH: MONTH 03 DAY 31 YEAR 1992
3. TIME OF DEATH: 12:20 A M
4. SOCIAL SECURITY NUMBER: 222-34-1908
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 44 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-18-47
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3329 E. MONUMENT STREET
10f. ZIP CODE: 21206
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.):
16b. KIND OF BUSINESS/INDUSTRY: JOHN HOPKINS HOSPITAL
17. FATHER'S NAME (First, Middle, Last): JOHN H. PRITCHETT
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET ANDERSON
19a. INFORMANT'S NAME (Type/Print): MICHELE TOWSON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1903 EUTAW PLACE A-1 /BALTIMORE, MD 21217
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GREENMOUNT CEMETERY DATE
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Norcad Scottie
22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Tonic clonic Seizures	15 minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Presumed CMV Encephalitis	2/92 - 3/92
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. AIDS	1985 - 1992

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Alan Wittstein M.D.
29c. LICENSE NUMBER: 19577
29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 600 N. WOLFE ST. BALTIMORE, MD. 21205
31. DATE FILED (Month, Day, Year): APR 0 2 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09190

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Carrie L. PARKER

2. DATE OF DEATH (Month, Day, Year): March 30 1992

3. TIME OF DEATH: 5:20 p M

4. SOCIAL SECURITY NUMBER: 218-22-6419

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 89 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 3 3 03

8. BIRTHPLACE (State or Foreign Country): Virginia

9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Baltimore City

10d. INSIDE CITY LIMITS?: 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 501 Dolphin Street #405

10f. ZIP CODE: 21217

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last):

18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie Washington

19a. INFORMANT'S NAME (Type/Print): Joseph Parker

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 501 Dolphin Street #405 Baltimore, Maryland 21217

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park DATE: 4/3/92

20c. LOCATION — City or Town, State: Arbutus, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Barry Harris

22. NAME AND ADDRESS OF FACILITY: Chatman-Harris F/H 1701 McCulloh St. Baltimore, Md21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Disseminated fungemia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?: 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?: 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?: 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY: M

28c. INJURY AT WORK?: 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: E. Rifkah, MD

29c. LICENSE NUMBER: N/A

29d. DATE SIGNED (Month, Day, Year):

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Elias Rifkah, M.D. c/o Maryland Hospital 837 Linden Avenue

31. DATE FILED (Month, Day, Year): APR 0 2 1992

32. REGISTRAR'S SIGNATURE: Jana Davidson-Kendall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09191 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): STEPHEN L. PEARL				2. DATE OF DEATH (Month, Day, Yr.): MAR. 31, 1992	3. TIME OF DEATH: 2:40 PM
4. SOCIAL SECURITY NUMBER: 009-24-7644	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JAN. 7, 1936	8. BIRTHPLACE (State or Foreign Country): VERMONT
9a. FACILITY NAME (If not institution, give street and number): MERCY MED. CENTER			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, CITY		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10e. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE, CITY	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4100 NORTH CHARLES STREET		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): INVESTMENT ANALYST	16b. KIND OF BUSINESS/INDUSTRY: ADAMS EXPRESS CO.	
17. FATHER'S NAME (First, Middle, Last): LLOYD PEARL		18. MOTHER'S NAME (First, Middle, Maiden Surname): FRANCES NOBLE	
19a. INFORMANT'S NAME (Type/Print): LAURA N. BAILEY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 HILLSIDE AVE. WINTHROP, MAINE. 04364	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): LAKEVIEW CEMETERY	DATE	20c. LOCATION — City or Town, State: BURLINGTON. VERMONT
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edison M. Perkins Jr		22. NAME AND ADDRESS OF FACILITY: HENRY W. JENKINS AND SONS 21212 4905 YORK ROAD. BALTIMORE, MD.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Circulatory failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastatic carcinoma of the lung
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Brain + liver Mets

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Marvin J. Feldman	29c. LICENSE NUMBER: D07830	29d. DATE SIGNED (Month, Day, Year): 3-31-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARVIN J. FELDMAN 301 St. Paul Place Baltimore, Md. 21202		
31. DATE FILED (Month, Day, Year): APR 02 1992	32. REGISTRAR'S SIGNATURE: Jean Marie Randall	

DHMH-16 Rev 1/89

10

92 09192

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Michael MICHAEL Richards RICHARDS				2. DATE OF DEATH (Month, Day, Year): 03 30 92	3. TIME OF DEATH: 11:05A M
4. SOCIAL SECURITY NUMBER: 068 34 8002	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 1-3-1920	8. BIRTHPLACE (State or Foreign Country): S.Hampton ENGLAND
9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: Silver Springs		9c. COUNTY OF DEATH: Mont Co.

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery County	10c. CITY, TOWN OR LOCATION: Silver Springs	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 11417 July Drive Apt 302		10f. ZIP CODE: 20904	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: no	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chef	16b. KIND OF BUSINESS/INDUSTRY: Food Industry	
17. FATHER'S NAME (First, Middle, Last): Angela Richeda		18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Fanchi	
19a. INFORMANT'S NAME (Type/Print): AnnRichards		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11417 July Drive#302 SilverSprings,MD20904	

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir 4/2/92	22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD 655W BaltimoreST,Balto.,MD 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cerdiac or respiratory errest, shock, or heart feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIOPULMONARY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. MYOCARDIAL INFARCTION and	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE [illegible] APR 2 1992 [illegible]

DHMH-16 Rev 1/89

92 09193

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frances N. Rambeau					2. DATE OF DEATH: MONTH 3 DAY 31 YEAR 92	3. TIME OF DEATH: 9:00 PM
4. SOCIAL SECURITY NUMBER: 214-20-9307	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 03/24/25	8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): 1303 W. Lombard St.			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore			9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT						
10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore				10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1303 W. Lombard St.		10f. ZIP CODE: 21223			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home				
17. FATHER'S NAME (First, Middle, Last): (1st Unobtainable) Mays	18. MOTHER'S NAME (First, Middle, Maiden Surname): (Unobtainable)					
19a. INFORMANT'S NAME (Type/Print): Americus John Rambeau	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2107 Cameron Drive, Dundalk, Md. 21222					
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park	DATE: 4/04	20c. LOCATION — City or Town, State: Glen Burnie, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L. Kaufman	22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Home 5695 Main St., Elkridge, Md. 21227					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial infarction	30 min
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Irreversible Congestive heart failure	2 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Arteriosclerotic Cardiovascular Dis	10 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Bronchitis Asthma COPD	18 yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
S. Rameren Attending Dr.		4/3/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible], M.D., P.A. 3721 Potee Street [illegible] MD 21225 [illegible]-1131

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 02 1992	Julia Davidson

DHMH-16 Rev 1/89

92 09194

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Samuel S Scott
2. DATE OF DEATH — MONTH: 3 DAY: 29 YEAR: 92
3. TIME OF DEATH: 7:20 AM
4. SOCIAL SECURITY NUMBER: 253-16-2248
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7-5-12
8. BIRTHPLACE (State or Foreign Country): U.S.A.
9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2223 Ettings Street
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cement Finisher
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATNER'S NAME (First, Middle, Last): Isaac Scott
18. MOTNER'S NAME (First, Middle, Maiden Surname): Nora
19a. INFORMANT'S NAME (Type/Print): Ernestine Edmunds
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2223 Etting St. Balto., Md. 21217
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cemetery — DATE: 4-4
20c. LOCATION — City or Town, State: Catonsville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Derrick C. Jones
22. NAME AND ADDRESS OF FACILITY: Derrick C. Jones F.H. 4611 Park Heights Ave. Balto., Md.15

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC PROSTATE CANCER — Approximate Interval Between Onset and Death: 9 MONTHS
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
BILATERAL PNEUMONITIS, ANEMIA
CHRONIC RENAL FAILURE
CONGESTIVE HEART FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 3-29-92
28b. TIME OF INJURY: 7:20 P M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Charles Rosenfarb M.D.
29c. LICENSE NUMBER: D31381
29d. DATE SIGNED (Month, Day, Year): 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHARLES ROSENFARB, M.D. 700 WASHINGTON BLVD, BALTO, MD 21230
31. DATE FILED (Month, Day, Year): APR 0 2 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

92-1831-510

Items: 23 part I,II,27,28a,b,c,d,e,f per MEO G-686 92 09195

1 - FOR STATE REGISTRAR 4/15/92 reb

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): KEVIN MARCUS SIMPSON
2. DATE OF DEATH (Month, Day, Year): 03 30 1992
3. TIME OF DEATH: 11:19 PM
4. SOCIAL SECURITY NUMBER: 214-08-8323
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 22 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-13-70
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2535 Carnaby DRIVE
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? U.S.A
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Gerald O. Simpson
16. MOTHER'S NAME (First, Middle, Maiden Surname): Bonita M. Anderson
19a. INFORMANT'S NAME (Type/Print): Bonita M. Anderson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2535 Carnaby DRIVE
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): King Mem Park — DATE: 4.3.92
20c. LOCATION — City or Town, State: Balto. Co. MD Dog Wood Rd
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph R. Walters Jr.
22. NAME AND ADDRESS OF FACILITY: Derrick C. Jones F.H. 4611 Park Heights Ave 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute combined narcotic and cocaine intoxication
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cardiomyopathy; status post remote, surgically repaired stab wound of heart

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending investigation 6 [X] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 3/30/92
28b. TIME OF INJURY: Ukn. M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: Unknown
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Unknown
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Unknown
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER: O.C.M.E
29d. DATE SIGNED (Month, Day, Year): 03-31-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK J. ORETTI 111 N. PENN ST. BALTIMORE, MARYLAND 21201
31. DATE FILED (Month, Day, Year): APR 0 2 1992
32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09196 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frank Shawhart					2. DATE OF DEATH (Month, Day, Year): 3-28-1992	3. TIME OF DEATH: 12:30A M
4. SOCIAL SECURITY NUMBER: 527-01-0125	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 1-9-1911	8. BIRTHPLACE (State or Foreign Country): Texas
9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:	
RESIDENCE OF DECEDENT						
10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore City			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 617 N. Robinson St.		10f. ZIP CODE: 21205			10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Security Guard		16b. KIND OF BUSINESS/INDUSTRY:			
17. FATHER'S NAME (First, Middle, Last): Walter Shawhart			18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Allen			
19a. INFORMANT'S NAME (Type/Print): Bertha Shawhart			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 617 N. Robinson St. Baltimore, Md. 21205			
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory	DATE	20c. LOCATION — City or Town, State: Baltimore City, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Philip Stark M00550	22. NAME AND ADDRESS OF FACILITY: Moran-Ashton Funeral Home, Inc. 3000 E. Baltimore St. Balto. Md. 21224					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Myocardial Infarction	12h
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Coronary Artery Disease	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Congestive Heart Failure
Cerebrovascular Accident

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: N/A M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael Gault, MD (House Officer)	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 3/28/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 301 Saint Paul Place Baltimore, MD 21202		
31. DATE FILED (Month, Day, Year): APR 0 2 1992	32. REGISTRAR'S SIGNATURE: [illegible]	

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12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09197 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Chester Lauren SMITH, Sr.				2. DATE OF DEATH (Month, Day, Year): April 1 1992	3. TIME OF DEATH: 2:45 am. M
4. SOCIAL SECURITY NUMBER: 219-38-6775	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 50 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-29-1941	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Rossville		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5945 Benton Heights Ave.		10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yrs. / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed	16b. KIND OF BUSINESS/INDUSTRY: Alarm Systems	
17. FATHER'S NAME (First, Middle, Last): Lauren E. Smith		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel V. Sullivan	
19a. INFORMANT'S NAME (Type/Print): Lorna S. Evey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3909 White Ave., Baltimore, Md. 21206	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Cemetery DATE: 4-4-92	20c. LOCATION — City or Town, State: Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Roy H. Cather Roy H. Cather	22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Advanced Carcinoma Colon with Metastasis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Leonard Daly M.D. STAFF Surgeon	29c. LICENSE NUMBER: D-17005	29d. DATE SIGNED (Month, Day, Year): 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GOPAL GURUSWAMY M.D. Franklin Square Hospital

31. DATE FILED (Month, Day, Year): APR 0 2 1992	32. REGISTRAR'S SIGNATURE: [illegible]

3

OHMH-18 Rev 1/89

92 09198

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be obtained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be detached for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Josephine Schwensen					2. DATE OF DEATH (Month, Day, Year): 3 30 1992		3. TIME OF DEATH: 1:05 P. M
4. SOCIAL SECURITY NUMBER: 218-26-8121	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-10-1909		8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2714 5th Ave.					9b. CITY, TOWN OR LOCATION OF DEATH: Carney		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Baltimore				10c. CITY, TOWN OR LOCATION: Carney		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2714 5th Ave.					10f. ZIP CODE: 21234		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Yrs.	College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY:		
17. FATHER'S NAME (First, Middle, Last): Ignatius Biebl					18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Unknown		
19a. INFORMANT'S NAME (Type/Print): John R. Schwensen, Sr.					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2714 5th Ave., Balto., Md. 21234		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Most Holy Redeemer Cem.	DATE: 4-2-92	20c. LOCATION — City or Town, State: Balto., Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roy H. Cather Roy H. Cather			22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, ehock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
e. **Acute Stroke**
DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST
b. **Generalized atherosclerosis**
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] M.D.	D-13649	▶ 4.1.92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Nestor M. Carmona, 6012 Harford Rd., Baltimore, Md. 21214

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 0 2 1992	[signature] Davidson-Randall

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OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09199
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert J. Staiger
2. DATE OF DEATH (Month, Day, Year): April 1, 1992
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212 12 4274
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb. 9, 1914
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 111 Trailsways Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: Middle River
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Middle River
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 111 Trailsways Rd.
10f. ZIP CODE: 21220
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 3
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager
16b. KIND OF BUSINESS/INDUSTRY: Food Service
17. FATHER'S NAME (First, Middle, Last): George Staiger
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elinor Andrusonas
19a. INFORMANT'S NAME (Type/Print): Judith Apperson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 411 Brownell Rd. Balto., MD 21220
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) ____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens — DATE: 4/3/92
20c. LOCATION — City or Town, State: Towson, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home P A, 1407 Eastern Ave. Balto. MD 21221

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Metastatic prostate Carcinoma	4 years
DUE TO (OR AS A CONSEQUENCE OF): b.	Hypertension	> 5 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Diabetes Mellitus.	> 5 years
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: M. So, M.D.
29c. LICENSE NUMBER: D26250
29d. DATE SIGNED (Month, Day, Year): 4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. So - 1447 York Rd, Lutherville, MD. 21093.
31. DATE FILED (Month, Day, Year): APR 02 1992
32. REGISTRAR'S SIGNATURE: Lina Davidson-Randall

DHMH-16 Rev 1/89

To the hospital or attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
To the funeral director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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92 09200

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Verlie Agnes Simpson

2. DATE OF DEATH (Month, Day, Year): April 1, 1992

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 236 24 5537

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 68 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): March 26 1924

8. BIRTHPLACE (State or Foreign Country): W. Va.

9a. FACILITY NAME (If not institution, give street and number): 4 East Orville Rd.

9b. CITY, TOWN OR LOCATION OF DEATH: Essex

9c. COUNTY OF OEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Essex

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 4 East Orville Rd.

10f. ZIP CODE: 21221

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR OATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. OECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+):

16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife

16b. KINO OF BUSINESS/INOUSTRY: Home

17. FATHER'S NAME (First, Middle, Last): William S. Pauley

18. MOTHER'S NAME (First, Middle, Maiden Surname): Fanny Brumfield

19a. INFORMANT'S NAME (Type/Print): William E. Simpson, Husband

19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 East Orville Rd. Balto., MD 21221

20a. METHOO OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place): Belair Memorial Gardens — DATE: 4/4/92

20c. LOCATION — City or Town, State: Belair, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Allen F. Bruzdzynski

22. NAME AND AOORESS OF FACILITY: Bruzdzinski Funeral Home PA, 1407 Eastern Ave. Balto., MD 21221

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory erreet, ehock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RIGHT UPPER LOBE OF LUNG

DUE TO (OR AS A CONSEQUENCE OF):

b. SQUAMOUS CELL CARCINOMA

Sequentielly list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Diseese or injury thet initieted events resulting in deeth) LAST

DUE TO (OR AS A CONSEQUENCE OF):

c. EMPITYSEMA

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERREO TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year)

26b. TIME OF INJURY M

26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

26d. DESCRIBE HOW INJURY OCCURED

26e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examinstion end/or investigation, in my opinion, death occured at the time, dete and place, and due to the cause(s) and mannar as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M Marshall DO

29c. LICENSE NUMBER: #42901

29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92

30. NAME AND AOORESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print): FRANKLIN SQUARE HOSP M. MARSHALL DO

31. DATE FILED (Month, Day, Year): APR 0 2 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

6

DHMH-16 Rev 1/89

92 09201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leonard W. Smith
2. DATE OF DEATH — MONTH: 3 DAY: 30 YEAR: 92
3. TIME OF DEATH: 9 10 AM M
4. SOCIAL SECURITY NUMBER: 226-30-2057
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 60 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-1-31
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Libert Med. Cen.
9b. CITY, TOWN OR LOCATION OF DEATH: Balto.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balto.
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 4401 Elkland Ave.
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: 11/65 - 3/79
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrator
16b. KIND OF BUSINESS/INDUSTRY: Liberty Med Cen.
17. FATHER'S NAME (First, Middle, Last): Leon Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marion Chisim
19a. INFORMANT'S NAME (Type/Print): Leonard W. Smith
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 Pearse Lane 20772
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Woodlawn Cem. — DATE:
20c. LOCATION — City or Town, State: Balto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey Miller
22. NAME AND ADDRESS OF FACILITY: Jeff Miller F / 1639 N. Broadway

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RECURRENT + METASTATIC ADENOCARCINOMA OF SIGMOID

DUE TO (OR AS A CONSEQUENCE OF): COLON WITH METASTASES TO LIVER + LUNG

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☑ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☑ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Harold E. Ramsey, MD.
29c. LICENSE NUMBER: D09694
29d. DATE SIGNED (Month, Day, Year): 3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 2600 LIBERTY HEIGHTS AVE. BALTIMORE, MARYLAND 21215

31. DATE FILED (Month, Day, Year): APR 02 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DNMH-16 Rev 1/89

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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92-1778-510

Items: 23 part I, II, 27, 28a,b, ,d,e,f per MEO G-686 92 09202

1 - FOR STATE REGISTRAR 4/24/92 reb

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIE D. SMITH
2. DATE OF DEATH: MONTH 03 DAY 27 YEAR 1992
3. TIME OF DEATH: 8:09 A.M
4. SOCIAL SECURITY NUMBER: 216-88-6723
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 26 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/1/65
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2243 MURA STREET
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: [illegible]

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2243 Mura Street
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY? U.S.A
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Willie Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): NORMA Hayes
19a. INFORMANT'S NAME (Type/Print): NORMA Hayes
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2234 MURA Street 21213
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Western Gdn — DATE:
20c. LOCATION — City or Town, State: Catonsville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Sofel Miller F/H 1639 N. Broadway

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Barbiturate Intoxication

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cocaine Use

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): found 3/27/92
28b. TIME OF INJURY: Ukn. M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED: Subject took drugs
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): found at home
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2243 Mura St. Baltimore, Md.

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): 03-27-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARGARET D. KOREN MD 111 PENN STREET BALTIMORE MARYLAND 21201
31. DATE FILED (Month, Day, Year): APR 02 1992
32. REGISTRAR: [signature]

DHMH-16 Rev 1/89

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92 09203

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): Alvin Wedlock			2. DATE OF DEATH (Month, Day, Year): 3 29 92	3. TIME OF DEATH: 11 14 PM
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3-3-1932	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hosp ctr		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: P.G

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Mt Rainor	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 3106 Perry Street		10f. ZIP CODE:	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: yes	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.):	16b. KIND OF BUSINESS/INDUSTRY: Labor worker
17. FATHER'S NAME (First, Middle, Last): Robert Summons		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nannie Wedlock	
19a. INFORMANT'S NAME (Type/Print): Stella G. McNair		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 46-37 181st St, Apt#2, Springfield Garden, NY 11413	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)		20b. PLACE AND OATE OF DISPOSITION (Name of cemetery, crematory or other place) / DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir — Joseph B. Tan Sant		22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD 655 W. Baltimore St, Balto, MD 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications thet caused the deeth. Do not enter the mode of dying, euch ae cerdiac or reapiretory arreet, shock, or heert failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. Severe Viral Syndrome
DUE TO (OR AS A CONSEQUENCE OF):
c.
OUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i.
Diabetes mellitus
Arteriosclerotic Cardiovascular Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. OESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Linda Whitby MD	29c. LICENSE NUMBER: D17162	29d. DATE SIGNED (Month, Day, Year): 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print): Linda Whitby MD 9556 Crain Hwy Upper Marlboro, MD 20772		
31. OATE FILED (Month, Day, Year): APR 2 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph	

DHMH-16 Rev 1/89

92-1815-510

92 09204

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARVIN Anthony WILLETT				2. DATE OF DEATH (Month, Day, Year): 03 29 1992	3. TIME OF DEATH: 7:27 P M
4. SOCIAL SECURITY NUMBER: 215-76-5443	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 25 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb 26, 1967	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 500 BLK GOLD ST.			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3453 Cottage Ave.		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Loader	16b. KIND OF BUSINESS/INDUSTRY: Conye Textile	
17. FATHER'S NAME (First, Middle, Last): Ralph Willett		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sheila Fisher	
19a. INFORMANT'S NAME (Type/Print): Sheila Willett	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3453 Cottage Ave. Baltimore, MD 21215		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery	DATE: 4/2	20c. LOCATION — City or Town, State: Baltimore Co., MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Barry L. Collins	22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, MD 21216		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gunshot Wound of Neck	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) STREET		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 3-29-1992	28b. TIME OF INJURY: 7:25 P	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: SUBJECT WAS SHOT
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): STREET			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 500 BLK GOLD ST

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis J. Clutemd	29c. LICENSE NUMBER: O.C.M.E	29d. DATE SIGNED (Month, Day, Year): ▶03-30-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 111 N. PENN ST. BALTIMORE, MARYLAND 21201		
31. DATE FILED (Month, Day, Year): APR 0 2 1992	32. REGISTRAR'S SIGNATURE: Julia Beardsley	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09205

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES WHITAKER			2. DATE OF DEATH (Month, Day, Year): 03 27 92	3. TIME OF DEATH: 1110P M
4. SOCIAL SECURITY NUMBER: 257-10-9987	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5-15-09	8. BIRTHPLACE (State or Foreign Country): Ga.
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 833 BONAPARTE AVENUE		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CRANE OPERATOR	16b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL	
17. FATHER'S NAME (First, Middle, Last): NELSON WHITAKER		18. MOTHER'S NAME (First, Middle, Maiden Surname): NANCY JENKINS	
19a. INFORMANT'S NAME (Type/Print): LUCILLE WHITAKER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 833 BONAPARTE AVE./BALTIMORE, MD 21218	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): WOODLAWN CEMETERY	DATE	20c. LOCATION — City or Town, State: WOODLAWN, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald Gaines		22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASCVD	10 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David Friedman M.D	29c. LICENSE NUMBER: D16770	29d. DATE SIGNED (Month, Day, Year): 4-1-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): APR 02 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

BY THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

NOTICE

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92-1818-510

92 09206

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kia G. Walker				2. DATE OF DEATH (Month, Day, Year): 3 30 92	3. TIME OF DEATH: 2:40 a.M
4. SOCIAL SECURITY NUMBER: 217-04-1646	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 21 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-3-71	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 2429 E. Hoffman Street			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1622 NORTHGATE ROAD		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 3rd yr.	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STUDENT	16b. KIND OF BUSINESS/INDUSTRY: SOCIAL SECURITY
17. FATHER'S NAME (First, Middle, Last):		18. MOTHER'S NAME (First, Middle, Maiden Surname): ONDRA WALKER	
19a. INFORMANT'S NAME (Type/Print): ONDRA WALKER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1622 NORTHGATE ROAD/BALTIMORE, MD 21218	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): ARBUTUS MEMORIAL PARK	DATE	20c. LOCATION — City or Town, State: ARBUTUS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Wonda Walker		22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gunshot Wound of Neck	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 3-30-92	28b. TIME OF INJURY: 2:24A.M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
	28d. DESCRIBE HOW INJURY OCCURED: Subject Shot		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2429 E. Hoffman Street	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis J. Cluteau	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): 3-30-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): APR 02 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Kendall

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

OHMH-16 Rev 1/89

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92 09207

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Myra Beatrice Weaver
2. DATE OF DEATH (Month, Day, Year): March 29, 1992
3. TIME OF DEATH: 6:00 AM
4. SOCIAL SECURITY NUMBER: 212-52-9278
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec. 10, 1911
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 4900 Grave Run Road
9b. CITY, TOWN OR LOCATION OF DEATH: Lineboro
9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Carroll
10c. CITY, TOWN OR LOCATION: Lineboro
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4900 Grave Run Road
10f. ZIP CODE: 21088
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): John E. Stiffler
18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude Richards
19a. INFORMANT'S NAME (Type/Print): A. Gertrude Reichard
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R.D. #2, Box 220, Seven Valleys, PA 17360
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lazarus Union Cemetery — DATE: Apr. 2, 1992
20c. LOCATION — City or Town, State: Lineboro, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. Hartenstein
22. NAME AND ADDRESS OF FACILITY: J. J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebrovascular Accident — Minutes
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cerebrovascular Small Vessel Disease — Years
DUE TO (OR AS A CONSEQUENCE OF):
c. Arteriosclerotic Vascular Disease — Years
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Valvular Heart Disease
True Dextrocardia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: K. Knapp D.O.
29c. LICENSE NUMBER: 05-4435-L
29d. DATE SIGNED (Month, Day, Year): March 30, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kieren P. Knapp D.O. 55 North Main St, Jacobus, PA 17407
31. DATE FILED (Month, Day, Year): APR 02 1992
32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be delivered within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH-16 Rev 1/89

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92-1826-510

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09208 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM D. ADAMS

2. DATE OF DEATH (Month, Day, Year): 03 30 1992

3. TIME OF DEATH: 1:50 P.M

4. SOCIAL SECURITY NUMBER: 216-28-4147

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 68 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 10-24-23

8. BIRTHPLACE (State or Foreign Country): Md.

9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY MEDICAL CENTER

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Baltimore, City

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 125 Balnew Avenue

10f. ZIP CODE: 21222

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-Employed

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): Irvin Adams

18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Smith

19a. INFORMANT'S NAME (Type/Print): Margaret Adams

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 125 Balnew Ave./ Baltimore, Md. 21222

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem. Cemetery — DATE:

20c. LOCATION — City or Town, State: Arbutus, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bernard D Johnson

22. NAME AND ADDRESS OF FACILITY: Wm.C. March F/H 1101 E. North Ave.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO — INQUIRY

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: O.C.M.E.

29d. DATE SIGNED (Month, Day, Year): 03-31-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK J. PERETTI M.D. 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year): APR 03 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09209

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary E. Alfinito

2. DATE OF DEATH (Month / Day / Year): 3 / 31 / 92

3. TIME OF DEATH: 8.45 P M

4. SOCIAL SECURITY NUMBER: 219-36-0695

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 52 yrs. YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Mar 7, 1940

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Uniom Memorial Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: - -

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 123 West 29th Street

10f. ZIP CODE: 21211

10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondery (0-12): 10th
College (1-4 or 5+):

18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerical

16b. KIND OF BUSINESS/INDUSTRY: Md Casualty Insurance Co

17. FATHER'S NAME (First, Middle, Last): Joseph Martin Gavin

18. MOTHER'S NAME (First, Middle, Maiden Surname): Charlotte M. Weitzel

19a. INFORMANT'S NAME (Type/Print): M. Thomas Gavin

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1211 Cape Sable Drive, Westminister, Md 21158

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cem — DATE: 4/6/92

20c. LOCATION — City or Town, State: Baltimore, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A Alan Seitz Jr.

22. NAME AND ADDRESS OF FACILITY: A. Alan Seitz, Jr. Funeral Home
3818 Roland Avenue, Baltom , Md 21211

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Insufficiency DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CVD DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: CAMINO Ignacio MD

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Union Memorial Hospital

31. DATE FILED (Month, Day, Year): APR 0 3 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92-1846-510
Item 23 Part I,II,27,28a,b,c,d,e,f, per MeEO, G-688, 6/5/92 gn

92 09210

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JERMAL BROWN					2. DATE OF DEATH (Month, Day, Year): 03 31 1992	3. TIME OF DEATH: 12:50 A.M
4. SOCIAL SECURITY NUMBER: 219-13-2541	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 5 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 03-02-87	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): MOUNT WASHINGTON PEDIATRIC HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore, City	10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 2220 Orleans Street		10f. ZIP CODE: 21231	10g. CITIZEN OF WHAT COUNTRY? U.S.A

11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Child; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Unemployed	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Ali Brown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Valarie Turner	
19a. INFORMANT'S NAME (Type/Print): Earline Brown	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2220 Orleans St./ Baltimore, Md. 21231		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cemetery	DATE:	20c. LOCATION — City or Town, State: Catonsville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bernard D Johnson	22. NAME AND ADDRESS OF FACILITY: Wm.C. March F/H 1101 E. North Ave.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Anoxic encephalopathy	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Multiple posterior rib fractures

24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ~~☐ Pending investigation~~ 6 X Could not be determined

28a. DATE OF INJURY (Month, Day, Year): December, 1989	28b. TIME OF INJURY: unknown M	28c. INJURY AT WORK? 1 ☐ YES 2 X NO	28d. DESCRIBE HOW INJURY OCCURED: unknown
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): unknown			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): unknown

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): 04-01-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK J.PERETTI M.D. 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year): APR 03 1992	32. REGISTRAR'S SIGNATURE: Julia Faith Rinker

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09211

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gloria T. Brown
2. DATE OF DEATH (Month, Day, Year): March 31, 1992
3. TIME OF DEATH: 11:25 A M
4. SOCIAL SECURITY NUMBER: 216-18-4992
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7. DATE OF BIRTH (Month, Day, Year): JAN. 11, 1924
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 47 STONE WAY PLACE
10f. ZIP CODE: 21236
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA; College (1-4 or 5+): NA
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): JAMES A. HARDESTY
18. MOTHER'S NAME (First, Middle, Maiden Surname): ADELE (SURNAME UNKNOWN)
19a. INFORMANT'S NAME (Type/Print): MICHAEL BROWN (SON)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 47 STONE WAY PLACE, BALTIMORE, MD 21236
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): DULANEY VALLEY MEM'L GARDENS — DATE
20c. LOCATION — City or Town, State: TIMONIUM, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOMES, INC. 9705 BELAIR RD., BALTIMORE, MD 21236

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrest	
DUE TO (OR AS A CONSEQUENCE OF):	b. Liver Failure	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c. Renal Failure	
DUE TO (OR AS A CONSEQUENCE OF):	d. Sepsis	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: SBE - artificial Mitral valve; Diabetes

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D24569
29d. DATE SIGNED (Month, Day, Year): 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Shorossky 660 Kenilworth Ave. Baltimore, MD 21212
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

10

92 09212

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alice M. Brightful

2. DATE OF DEATH — MONTH: 3 DAY: 30 YEAR: 92

3. TIME OF DEATH: 105 P M

4. SOCIAL SECURITY NUMBER: 214-20-7233

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 78 YRS.

IF UNDER 1 YEAR — MONTHS: DAYS: IF UNDER 24 HRS. — HOURS: MIN.:

7. DATE OF BIRTH (Month, Day, Year): 12-27-13

8. BIRTHPLACE (State or Foreign Country): Md

9a. FACILITY NAME (If not institution, give street and number): John Deaton Medical

9b. CITY, TOWN OR LOCATION OF DEATH: Balto

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Glen Burnie

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 7258 Furnace Branch

10f. ZIP CODE: 21060

10g. CITIZEN OF WHAT COUNTRY? U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 6
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)

16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Frank Laverne

18. MOTHER'S NAME (First, Middle, Maiden Surname): Maude Willette

19a. INFORMANT'S NAME (Type/Print): Carl Brightful, Jr

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7258 Furnace Branch Glen Burnie, Md 21060

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville Vet Cem DATE: 4392

20c. LOCATION — City or Town, State: Crownsville, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Portia Elvron

22. NAME AND ADDRESS OF FACILITY: March F. H. West 4300 Wabash Ave

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pneumonia, (Bronchopneumonia).
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pressure Sores.
Dementia of uncertain etiology.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: George Taler M.D.

29c. LICENSE NUMBER: D19858

29d. DATE SIGNED (Month, Day, Year): 3/30/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): George Taler, M.D. 611 S. Charles St. Baltimore, Md. 21230

31. DATE ACCEPTED (Month, Day, Year): APR 0 3 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

6

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09213
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY BULMASH				2. DATE OF DEATH (Month, Day, Year): 03 30 1992	3. TIME OF DEATH: 6:05P M
4. SOCIAL SECURITY NUMBER: 212-44-5835	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 06/03/1913	8. BIRTHPLACE (State or Foreign Country): RUMANIA
9a. FACILITY NAME (If not institution, give street and number): (GREATER BALTIMORE MEDICAL CENTER) G.B.M.C., 6701 N. CHARLES STREET				9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON	9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7 SLADE AVENUE, APT. 616		10f. ZIP CODE: 21208		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ~~3 ☒ Widowed~~ 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MANAGER		16b. KIND OF BUSINESS/INDUSTRY: PRINTING PLANT	
17. FATHER'S NAME (First, Middle, Last): HYMAN PARCOVER				18. MOTHER'S NAME (First, Middle, Maiden Surname): RUTH WARSHAWSKY	
19a. INFORMANT'S NAME (Type/Print): MOLLIE SCHWARTZ		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 SLADE AVE., APT. 909 BALTO., MD 21208			
20a. METHOD OF DISPOSITION: ~~1 ☒ Burial~~ 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): BETH EL MEMORIAL PARK DATE: 4/1/92		20c. LOCATION — City or Town, State: RANDALLSTOWN, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellenore Levinson		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PROGRESSIVE METASTATIC OVARIAN CANCER
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cardio respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D-20637
29d. DATE SIGNED (Month, Day, Year): ▶ 3-31-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frances C. Grumland M.D., 6701 N. Charles St., Balto., md. 21204

31. DATE FILED (Month, Day, Year): APR 03 1992
32. REGISTRAR'S SIGNATURE: [signature]

OHMH-16 Rev 1/89

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92 09214

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph Frank BELLAMY				2. DATE OF DEATH: MONTH 4 DAY 1 YEAR 92	3. TIME OF DEATH: 11:40 a M
4. SOCIAL SECURITY NUMBER: 235-26-2236	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 12, 1922	8. BIRTHPLACE (State or Foreign Country): WestVirginia
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Rossville		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT					
10a. STATE: Md.	10b. COUNTY: BAltimore	10c. CITY, TOWN OR LOCATION: Essex			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 182 Orville Road			10f. ZIP CODE: 21221		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1945		13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Welder		16b. KIND OF BUSINESS/INDUSTRY: American Standard	
17. FATHER'S NAME (First, Middle, Last): Glen Lee Bellamy Sr.			18. MOTNER'S NAME (First, Middle, Maiden Surname): Lois Wright		
19a. INFORMANT'S NAME (Type/Print): Paralee Bellamy		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 182 Orville Road Baltimore Md. 21221			
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Cemetery 4/4/92	DATE	20c. LOCATION — City or Town, State: Baltimore Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home		22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MAceAve. 21221			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	e. Recurrent Carcinomas upper abdomen with Metastasis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury that initiated events resulting in deeth) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Nome 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Nomicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(e) and menner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
G Gurusswamy MD Staff Surgeon	D17005	▶ 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GOPAL GURUSWAMY MD. Franklin Square hospital 11:40AM

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 0 3 1992	Julia Davidson-Randall

DHMN-16 Rev 1/89

92-1893-510

92 09215

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Melvin Leroy Carter

2. DATE OF DEATH Month: 04 Day: 02 Year: 1992

3. TIME OF DEATH: 10:15 A. M

4. SOCIAL SECURITY NUMBER: 212 01 4429

5. SEX: 1 XX M 2 ☐ F

6. AGE (In yrs. last birthday): 78 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 10/9/13

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Rear of 507 W. 28th Street

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: --

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO

10e. STREET AND NUMBER: 507 W. 28th Street

10f. ZIP CODE: 21211

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Traffic Manager

16b. KIND OF BUSINESS/INDUSTRY: Steel Manufacturing

17. FATHER'S NAME (First, Middle, Last): Maurice Carter

18. MOTHER'S NAME (First, Middle, Maiden Surname): Lydia Sims

19a. INFORMANT'S NAME (Type/Print): Barbara Fosnaught

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2802 Roselawn Avenue Baltimore, Maryland 21214

20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Providence Cemetery — DATE: 4/6

20c. LOCATION — City or Town, State: Towson, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lynn Burgee Henss

22. NAME AND ADDRESS OF FACILITY: Burgee-Henss Funeral Home
3631 Falls Road, Baltimore, Maryland 21211

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO — Inspection

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify): Alley

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Maryee Mechler

29c. LICENSE NUMBER: O.C.M.E.

29d. DATE SIGNED (Month, Day, Year): 4/03/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): APR 0 3 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

12

92 09216

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Roy Clayton Calhoun — Roy Calhoun
2. DATE OF DEATH (Month, Day, Year): 4/1/92
3. TIME OF DEATH: 1:00 AM
4. SOCIAL SECURITY NUMBER: 217-68-1118
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 36 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7/24/55 — 7/24/55
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2901 N. Calvert St. 21218
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: ---

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore City
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2901 N. Calvert St — Basement Apt.
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — Americen Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): House Painter
16b. KIND OF BUSINESS/INDUSTRY: Residential Painting
17. FATHER'S NAME (First, Middle, Last): Leon Clark Calhoun
18. MOTHER'S NAME (First, Middle, Maiden Surname): Nancy Lee Clayton
19a. INFORMANT'S NAME (Type/Print): Nancy L. Ridgeway
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2901 N. Calvert St. Baltimore, MD 21218
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc. — DATE: 4/2
20c. LOCATION — City or Town, State: Baltimore City MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb
22. NAME AND ADDRESS OF FACILITY: Cremation Society of Md., Inc. 299 Frederick Road Balto, MD 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acquired Immune Deficiency Syndrome	24-5
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	HUMAN IMMUNODEFIENCY VIRUS	6-7 yrs
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: A. Burton MD
29c. LICENSE NUMBER: PENDING
29d. DATE SIGNED (Month, Day, Year): 4/1/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Albert Andrew Burton 4505 KESWICK BALTIMORE MD 2121
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

3

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09217
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dustin A. Cascioli-Vain

2. DATE OF DEATH (Month, Day, Year): 04 - 01 - 92

3. TIME OF DEATH: 9:11 p (M)

4. SOCIAL SECURITY NUMBER: None

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS —, DAYS 2; IF UNDER 24 HRS.: HOURS, MIN.

7. DATE OF BIRTH (Month, Day, Year): 03-30-92

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 3304 English Consul Avenue

10f. ZIP CODE: 21230

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: —

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): None; College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None

16b. KIND OF BUSINESS/INDUSTRY: —

17. FATHER'S NAME (First, Middle, Last): Daniel A. Vain

18. MOTHER'S NAME (First, Middle, Maiden Surname): Stephanie Cascioli

19a. INFORMANT'S NAME (Type/Print): Gwendolyn S. Cascioli

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3304 English Consul Ave.; Baltimore, Md. 21230

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc. — DATE: 4/2

20c. LOCATION — City or Town, State: Baltimore, Md. 21229

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Christopher H. Mikes

22. NAME AND ADDRESS OF FACILITY: Howard H. Hubbard Funeral Home, Inc. 4107 Wilkens Ave.; Baltimore, Md. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Extreme Prematurity

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Respiratory Distress Syndrome

DUE TO (OR AS A CONSEQUENCE OF):

c. Possible DIC / Thrombocytopenia

DUE TO (OR AS A CONSEQUENCE OF):

d. Circulatory instability

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pneumothorax

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): —

28b. TIME OF INJURY: — M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED: —

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): —

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): —

29a. CERTIFIER (Check only one):
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Madhu Nigam, Resident

29c. LICENSE NUMBER: —

29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MADHU NIGAM ST AGNES HOSPITAL

31. DATE FILED (Month, Day, Year): APR 0 3 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/69

92 09218

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROBA, LEORA — LEORA M. DOROBA
2. DATE OF DEATH (Month, Day, Year): 03 30 92
3. TIME OF DEATH: 4:20PM M
4. SOCIAL SECURITY NUMBER: 214-20-6101
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 94 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): April 12, 1897
8. BIRTHPLACE (State or Foreign Country): Indiana
9a. FACILITY NAME (If not institution, give street and number): Caton Manor Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Balto. City
9c. COUNTY OF DEATH: ---------

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: -------
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3330 Wilkens Ave.
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): waitress
16b. KIND OF BUSINESS/INDUSTRY: food service
17. FATHER'S NAME (First, Middle, Last): Lambert H. Pollitt
18. MOTHER'S NAME (First, Middle, Maiden Surname): Permelia Anne Stiers
19a. INFORMANT'S NAME (Type/Print): Leroy E.Gerding,Jr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1107 North Point Blvd. Balto.Md. 21224
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore National Cem.
20c. LOCATION — City or Town, State: Balto.Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James J. Burnside, Jr.
22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto.Md. 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final diseese or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ATRIAL FIBRILATION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N/A
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N A
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED: N A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Surjit Julka
29c. LICENSE NUMBER: D26395
29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr.Surjit S.Julka 821 N. Eutaw St.Bal.Md. 21201
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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item4; film 9-686;
4-14-92; dr

92 09219

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harold N. ELLIOTT

2. DATE OF DEATH (Month, Day, Year): April 1 1992

3. TIME OF DEATH: 10:22 pm. M

4. SOCIAL SECURITY NUMBER: 216-32-~~2524~~ 2542

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 55 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 01-30-1937

8. BIRTHPLACE (State or Foreign Country): Balto., Md.

9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: N/A

10c. CITY, TOWN OR LOCATION: Baltimore City

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 5961 Glenfalls Avenue

10f. ZIP CODE: 21206

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: Reserves

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th Grade
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Foreman

16b. KIND OF BUSINESS/INDUSTRY: City of Baltimore

17. FATHER'S NAME (First, Middle, Last): Harold Elliott

18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Huber

19a. INFORMANT'S NAME (Type/Print): Mary Elizabeth Elliott

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5961 Glenfalls Avenue, Baltimore, Maryland 21206

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery — DATE: 4/4

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathleen M. Murphy

22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Obstructive Pulmonary Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M Marshall MD

29c. LICENSE NUMBER: N/A

29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Melanie Marshall, MD. 9000 Franklin Square Drive, Baltimore, Maryland 21237

31. DATE FILED (Month, Day, Year): APR 0 3 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edwin Henry EIFERT, Sr.

2. DATE OF DEATH (Month, Day, Year): April 1, 1992.

3. TIME OF DEATH: 7:50 P.M

4. SOCIAL SECURITY NUMBER: 213-18-6895

5. SEX: 1 ☒ M 2 ☐ F

6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

7. DATE OF BIRTH (Month, Day, Year): 10/07/1916

8. BIRTHPLACE (State or Foreign Country): Baltimore, Md.

9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: N/A

10c. CITY, TOWN OR LOCATION: Baltimore City

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 6001 Plumer Avenue

10f. ZIP CODE: 21206

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO
IF YES, GIVE WAR OR DATES: WWII

13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 8 Years
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic

16b. KIND OF BUSINESS/INDUSTRY: Self Employed

17. FATHER'S NAME (First, Middle, Last): Louis C. Eifert

18. MOTHER'S NAME (First, Middle, Maiden Surname): Pauline Gebhardt

19a. INFORMANT'S NAME (Type/Print): Marie Eifert

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6001 Plumer Avenue, Baltimore, Maryland 21206

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery — DATE: 4/4

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph B. Bell Jr.

22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Bronchogenic Carcinoma.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Diabetes.
DUE TO (OR AS A CONSEQUENCE OF):
c. Renal Metastasis.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jang-Ho Cha MD PhD

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jang-Ho Cha, M.D. 9000 Franklin Square Drive, Baltimore, MD. 21237.

31. DATE FILED (Month, Day, Year): APR 0 3 1992

32. REGISTRAR'S SIGNATURE: Jane Davidson-Kendall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frances Feaster

2. DATE OF DEATH (Month, Day, Year): 3 31 1992

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 241-14-8987

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 75 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 4-15-1916

8. BIRTHPLACE (State or Foreign Country): S.C.

9a. FACILITY NAME (If not institution, give street and number): 2603 Lynhurst Avenue

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 2603 Lynhurst Avenue

10f. ZIP CODE: 21216

10g. CITIZEN OF WHAT COUNTRY? U S A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)

16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Benjamin Davis

18. MOTHER'S NAME (First, Middle, Maiden Surname): Roseana Kennedy

19a. INFORMANT'S NAME (Type/Print): John Feaster, Jr

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2603 Lynhurst Avenue Baltimore, Md 21216

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet — DATE: 4692

20c. LOCATION — City or Town, State: Owings Mills, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Glynn B. Scott

22. NAME AND ADDRESS OF FACILITY: March F/H West
4300 Wabash Avenue

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	aspiration pneumonia	1 week
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	cerebrovascular accident	3 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.	hypertension	10 years
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard A Berg, MD

29c. LICENSE NUMBER: D20604

29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard A. Berg; Suite 365; Commer Centre East; 1777 Reisterstown Rd; Pikesville, Md 21208

31. DATE FILED (Month, Day, Year): APR 0 3 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09222
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERTHA L. GORDON
2. DATE OF DEATH: MONTH 3 DAY 28 YEAR 92
3. TIME OF DEATH: 3:40 PM
4. SOCIAL SECURITY NUMBER: 215-30-1179
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 59 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-29-32
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): University Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Balto
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balto
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1416 W. Franklin St
10f. ZIP CODE: 21223
10g. CITIZEN OF WHAT COUNTRY?: U.S.A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Willie E. Travis
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mattie Lee Winberly
19a. INFORMANT'S NAME (Type/Print): Theresa Thomas
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 913 N. Woodington Rd Balto. Md 21229
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Md Nat Mem Park — DATE: 4-4-92
20c. LOCATION — City or Town, State: Laurel, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale March
22. NAME AND ADDRESS OF FACILITY: March F.H. West 4300 Wabash Ave

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	METABOLIC ACIDOSIS	3 DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	RENAL FAILURE	28 DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
c.	METASTATIC SMALL CELL LUNG CANCER	33 DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: GASTRO INTESTINAL BLEEDING

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Peter W Wisniewski MD
29c. LICENSE NUMBER: D 40370
29d. DATE SIGNED (Month, Day, Year): 5/28/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER L WISNIEWSKI 22 S. GREENE ST BALTIMORE, MD 21201
31. DATE FILED (Month, Day, Year): APR 03 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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92-1223-510

Items: 23 part I,II,27, per MEO G-686 4/6/92 reb

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09223 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RAYMOND GOLDFINE			2. DATE OF DEATH (Month, Day, Year): 03 03 1992	3. TIME OF DEATH: 5:56 p M
4. SOCIAL SECURITY NUMBER: 214-38-6534	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 54 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 24, 1938
8. BIRTHPLACE (State or Foreign Country): Baltimore, Md.				
9a. FACILITY NAME (If not institution, give street and number): 5625 O'DONNELL STREET	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH: Baltimore Co.		
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Dundalk	10c. CITY, TOWN OR LOCATION: Dundalk	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 2836 Nathanial Way	10f. ZIP CODE: 21236	10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Jewish	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver	16b. KIND OF BUSINESS/INDUSTRY: Self Employed		
17. FATHER'S NAME (First, Middle, Last): unknown	18. MOTHER'S NAME (First, Middle, Maiden Surname): unknown			
19a. INFORMANT'S NAME (Type/Print): Sheila P. Goldfine	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 Chelsea St. #2a E. Boston, Mass. 02128			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Cem. DATE: 4/1	20c. LOCATION — City or Town, State: Owings, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ F. Bernard Hunt	22. NAME AND ADDRESS OF FACILITY: Hunt Funeral Home 2801 7th St. N.E. Wash. D.C. 20017			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneumonia	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: Seizure disorder

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) MALL PARKING LOT	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ 03/04/1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 111 PENN STREET BALTIMORE, MARYLAND 21201		
31. DATE FILED (Month, Day, Year): APR 0 3 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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92 09224

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CAMILLIA GIBSON			2. DATE OF DEATH (Month, Day, Year): 03/24/1992	3. TIME OF DEATH: 02:00p M
4. SOCIAL SECURITY NUMBER: 246 20 7119	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 yrs. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 08/9/1921	8. BIRTHPLACE (State or Foreign Country): USA
9a. FACILITY NAME (If not institution, give street and number): GBMC 6701 NORTH CHARLES ST		9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5704 WINNER AVE		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: usa

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer	16b. KIND OF BUSINESS/INDUSTRY: Domestic	
17. FATHER'S NAME (First, Middle, Last): Morris Green		18. MOTHER'S NAME (First, Middle, Maiden Surname): Eliza Green	
19a. INFORMANT'S NAME (Type/Print): William E. Gibson Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5704 Winner Ave. Baltimore, Md. 21215	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Clark & Gibson Cem. DATE: 3/29	20c. LOCATION — City or Town, State: Silver Comm, SC.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] B. Cagle		22. NAME AND ADDRESS OF FACILITY: Chatman-Harris F.H. 1701 McCulloh St. Balto, Md. 21217	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. cerebral hypoxia
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. metastatic breast cancer
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D 27730	29d. DATE SIGNED (Month, Day, Year) ▶ 3/24/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GARY COHEN, MD, 6701 N. CHAS. ST. BALTO MD 21204		
31. DATE FILED (Month, Day, Year): APR 0 3 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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92 09225

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SIDNEY RAYMOND GREENWALD Sidney Greenwald			2. DATE OF DEATH (Month, Day, Year): 3-30-92	3. TIME OF DEATH: 1420 M
4. SOCIAL SECURITY NUMBER: 212-01-9969	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): FEB. 29, 1911	8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3000 FALLSTAFF MANOR CT. #D		10f. ZIP CODE: 21209	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): WATCHMAKER	16b. KIND OF BUSINESS/INDUSTRY: JEWELRY	
17. FATHER'S NAME (First, Middle, Last): FRANK GREENWALD		18. MOTNER'S NAME (First, Middle, Maiden Surname): JOHANNA ELTERS	
19a. INFORMANT'S NAME (Type/Print): MRS. VERA GREENWALD		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3000 FALLSTAFF MANOR CT., APT. D BALTO., MD 21209	
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): BETH EL MEMORIAL PARK	DATE: 4/1/92	20c. LOCATION — City or Town, State: RANDALLSTOWN, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Elenore Levinson		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure	4 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Renal Failure	7 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Adenocarcinoma of lung with Metastatic to Retroperitoneal space	2 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P Abdominal Aortic Aneurysm Resection
Chronic Obstructive Pulmonary Disease

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Sie K. Ong MD House Physician	29c. LICENSE NUMBER: D36456	29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sie Kiem Ong MD. Baltimore County General Hospital, Randallstown, MD 21133			
31. DATE FILED (Month, Day, Year): APR 03 1992	32. REGISTRAR'S SIGNATURE: [illegible]		

DHMH-16 Rev 1/89

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92 09226

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SEEDON GRIKIT
2. DATE OF DEATH (Month, Day, Year): APRIL 01, 1992
3. TIME OF DEATH: 4:35 a. M
4. SOCIAL SECURITY NUMBER: 215-07-7269
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 08/14/09
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE
9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: ANNE ARUNDEL
10c. CITY, TOWN OR LOCATION: MILLERSVILLE
10d. INSIDE CITY LIMITS? 1 [ ] YES [X] NO
10e. STREET AND NUMBER: 569 BRIGHTWOOD ROAD
10f. ZIP CODE: 21108
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Buyer
16b. KIND OF BUSINESS/INDUSTRY: Wholesale
17. FATHER'S NAME (First, Middle, Last): Andrew Grikit
18. MOTHER'S NAME (First, Middle, Maiden Surname): Matty Osol
19a. INFORMANT'S NAME (Type/Print): GLORIA GRIKIT
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 569 BRIGHTWOOD ROAD MILLERSVILLE, MD. 21108
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Balt-Washington Crematory — DATE: 4/2/92
20c. LOCATION — City or Town, State: Laurel, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE
22. NAME AND ADDRESS OF FACILITY: AMBROSE FUNERAL HOME, INC. 1328 SULPHUR SPRING ROAD 21227

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPIRATION PNEUMONIA, RECURRENT — DUE TO (OR AS A CONSEQUENCE OF): — Approximate Interval Between Onset and Death: 1 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P STROKE
CELLULITIS
DECUBITUS ULCER

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Terrence McMullen MD
29c. LICENSE NUMBER: D32215
29d. DATE SIGNED (Month, Day, Year): 4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. TERRENCE McMULLEN 7706 QUARTERFIELD RD. Glen Burnie 21061
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09227

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOUISE GLAROS
2. DATE OF DEATH (Month, Day, Year): 04 01 1992
3. TIME OF DEATH: 8:57 A.M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 64 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 22, 1927
8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE
9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: ~~Rexxyxxxkkk~~ Essex
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 12 Dahlia Lane
10f. ZIP CODE: 21021 (21221)
10g. CITIZEN OF WHAT COUNTRY?: Maryland-USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5 +)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY: food industry
17. FATHER'S NAME (First, Middle, Last): Otto Hart
18. MOTHER'S NAME (First, Middle, Maiden Surname): Millie Breedin
19a. INFORMANT'S NAME (Type/Print): Sylvia Piunti
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11733 Hamilton Place 21162
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc. DATE
20c. LOCATION — City or Town, State: Balitimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Colt Connelly
22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home of Dundalk 7110 Sollers Point Road Balto. 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive Arteriosclerotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Aaron Locke MD
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): ▶ 04-02-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. AARON LOCKE, MD 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year): APR 03 1992
32. REGISTRAR'S SIGNATURE: Irene Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09228
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Hughes~~ Charles M. Hughes			2. DATE OF DEATH (Month, Day, Year): 03 31 92	3. TIME OF DEATH: 6:40P M
4. SOCIAL SECURITY NUMBER: 214-40-3193	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12/31/41	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): MERCY HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: ------

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: ------	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 400 E. FORT AVENUE		10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: NAVY	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: X WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): ----	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ADMINISTRATOR	16b. KIND OF BUSINESS/INDUSTRY: STA-ILA CONTAINER ROYALTY FUND	
17. FATHER'S NAME (First, Middle, Last): RICHARD HUGHES		16. MOTHER'S NAME (First, Middle, Maiden Surname): HONORA THORNTON	
19a. INFORMANT'S NAME (Type/Print): SUSAN C. HUGHES	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3043 SOUNDING DR. EDGEWOOD, MD 21040		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): LOUNON PARK CEMETERY	DATE: 4/4/92	20c. LOCATION — City or Town, State: BALTO., MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles L. Stevens Jr.	22. NAME AND ADDRESS OF FACILITY: CHARLES L. STEVENS FUNERAL HOME, INC. 1501 E. FORT AVE. BALTO, MD 21230		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. END STAGE ISCHEMIC HEART DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. SEVERLY IMPAIRED LEFT VENTRICULAR CONTRACTILITY

DUE TO (OR AS A CONSEQUENCE OF):

c. ANOXIC ENCEPHALOPATHY.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

POST CARDIAC ARREST AT HOME PRIOR TO ADMISSION TO HOSPITAL.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify); 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one):
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Douglas Clarke, M.D.	29c. LICENSE NUMBER: D31476	29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. DOUGLAS CLARKE, M.D. 7505 OSLER DR. TOWSON, MD		
31. DATE FILED (Month, Day, Year): APR 0 3 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

15

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09229
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month - Day - Year)	3. TIME OF DEATH
Ellen	Winifred	Harris	04 - 01 - 92	PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
212-10-4155	1 ☐ M 2 ☒ F	78 YRS.			04-05-13	Pennsylvania

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
6401 Loch Raven Blvd. Apt. 235	Baltimore City	n/a

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	n/a	Baltimore City	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
6401 Loch Raven Blvd.	21239	U.S.A

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
8 yrs.		Homemaker	N/A

17. FATHER'S NAME (First, Middle, Last)	16. MOTHER'S NAME (First, Middle, Maiden Surname)
Patrick Joseph Dunphy	Winifred Cecilia Haney

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary T. Buhl	4926 Ten Mills Road, Columbia, Maryland 21044

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	New Cathedral Cemetery	4/4/92	Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ John G. Reitz John G Reitz	Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the daeth. Do not enter the mode of dying, such ae cerdiec or respiratory arrest, ahock, or heart feilure. List only one ceuse on aech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Coronary Artery Disease

DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertension

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
S. Gail Wilson MD	D22719	▶ 4/2/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 0 3 1992	Julia Davidson-Randall

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09230
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frederick Dean Hicks

2. DATE OF DEATH Month: 4 Day: 1 Year: 92

3. TIME OF DEATH: 7:45 A. M

4. SOCIAL SECURITY NUMBER: 212-82-0697

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 30 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS
IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 5-22-61

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Residence 1722 E. 28 th St.

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 1722 E. 28 th St.

10f. ZIP CODE: 21218

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yee or No— It yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — Americen Indian, Black, White, etc. Specify: Black

15. DECEOENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 11 th
College (1-4 or 5+):

16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook

16b. KINO OF BUSINESS/INOUSTRY: Food Service

17. FATHER'S NAME (First, Middle, Last): John Hicks

18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Puryear

19a. INFORMANT'S NAME (Type/Print): Grace Hicks

19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1722 E. 28 th St. Balto., Md. 21218

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): BA/HO. CEM. Baltimore, Maryland — DATE: 4-7-92

20c. LOCATION — City or Town, State: Baltimore

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John B. Cook

22. NAME AND ADDRESS OF FACILITY: Chatman - Harris
1701 McCulloh St. Balto., Md.21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicstions thet caused the death. Do not enter the mode of dying, such ee cardiec or reepiratory errest, shock, or heert feiiure. Liet only one ceuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Pseudomonas Lung Abscess — 6 months
DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly liat conditions, if sny, lesding to immediete ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. Acquired Immuno deficiency Syndrome — ~~6 mo~~ 5 years
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditione contributing to death but not resulting in the underlying cauee given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): None

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. OESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(e) and manner ee stated.
2 [ ] MEOICAL EXAMINER: On the beele of examination and/or inveatigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner ee stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert R. Kent, MD.

29c. LICENSE NUMBER: D06966

29d. DATE SIGNED (Month, Day, Year): 4/3/92

30. NAME AND AOORESS OF PERSON WHO COMPLETEO CAUSE OF OEATH (ITEM 27) (Type, Print): Robert Kent, MD 101 W. Read St suite211 Baltimore MD 21201

31. DATE FILED (Month, Day, Year): APR 0 3 1992

32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

92 09231

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): David R. Hoefner Jr.
2. DATE OF DEATH (Month, Day, Year): March 31, 1992
3. TIME OF DEATH:
4. SOCIAL SECURITY NUMBER: 213-07-0558
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 10, 1916
8. BIRTHPLACE (State or Foreign Country): MAryland
9a. FACILITY NAME (If not institution, give street and number): 1205 Hanson Road
9b. CITY, TOWN OR LOCATION OF DEATH: Edgewood
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: BAltimore
10c. CITY, TOWN OR LOCATION: Middle River
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1222 Stumpfs Road
10f. ZIP CODE: 21220
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY: Beth Steel
17. FATHER'S NAME (First, Middle, Last): David R. Hoefner Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Parks
19a. INFORMANT'S NAME (Type/Print): Florence Hoefner
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1222 Stumpfs Road Baltimore MArylnad 21220
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cemetery — DATE: 4/3/92
20c. LOCATION — City or Town, State: Baltimore MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home
22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MAce Ave. 21221

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Myocardial infarction	minutes
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Arteriosclerotic cardiovascular disease	years
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Fernando DMD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 3-31-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FERNANDO DUBRAL, M.D. 4000 ANNAPOLIS Rd. BALTIMORE, Md
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

4

92-1881-510

Item: 1, per F.H. G-686 4/6/92 reb

92 09232

1. FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~ALAN~~ Allan S. JACKSON SR.

2. DATE OF DEATH (Month, Day, Year): 04 01 1992

3. TIME OF DEATH: 8:35 P. M

4. SOCIAL SECURITY NUMBER: 215-98-9612

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 27 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 8/5/64

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY BURN UNIT

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY

9c. COUNTY OF DEATH: -------

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: -------

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 3801 2nd STREET

10f. ZIP CODE: 21225

10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th GRADE; College (1-4 or 5+): -------

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF EMPLOYED

16b. KIND OF BUSINESS/INDUSTRY: VENDOR

17. FATHER'S NAME (First, Middle, Last): JOSEPH E. JACKSON

18. MOTHER'S NAME (First, Middle, Maiden Surname): EVELYN E. ALLEN

19a. INFORMANT'S NAME (Type/Print): EVELYN E. JACKSON

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1424 REYNOLDS ST., BALTO., MD 21230

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY DATE: 4/6/92

20c. LOCATION — City or Town, State: BALTO., MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Stuley Dodd

22. NAME AND ADDRESS OF FACILITY: CHARLES L. STEVENS FUNERAL HOME, INC 1501 E. FORT AVE. BALTO., MD 21230

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

a. Thermal Injuries

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. _____

DUE TO (OR AS A CONSEQUENCE OF):

c. _____

DUE TO (OR AS A CONSEQUENCE OF):

d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

26a. DATE OF INJURY (Month, Day, Year): 3/31/92

26b. TIME OF INJURY: 1530 M

26c. INJURY AT WORK? 1 [ ] YES 2 [X] NO

26d. DESCRIBE HOW INJURY OCCURED: Victim of House fire

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 3801 2nd ST. Balto, MD

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Aaron Wicke MD

29c. LICENSE NUMBER: O.C.M.E.

29d. DATE SIGNED (Month, Day, Year): ▶04-02-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. AARON WICKE MD 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year): APR 0 3 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

TO BE FILED BY HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO BE FILED BY FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1

92-1847-510

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09233 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NICHOLAS J. JACKSON
2. DATE OF DEATH (Month, Day, Year): 03 31 1992
3. TIME OF DEATH: 2:10 PM
4. SOCIAL SECURITY NUMBER: NONE
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 0 YRS. IF UNDER 1 YEAR: MONTHS 1 DAYS 6 IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 2/24/92
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 3801 2nd ST,
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: -------

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: ---------
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3801 2nd STREET
10f. ZIP CODE: 21225
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 College (1-4 or 5+): ----
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NONE
16b. KIND OF BUSINESS/INDUSTRY: ------
17. FATHER'S NAME (First, Middle, Last): ALLEN S. JACKSON
18. MOTHER'S NAME (First, Middle, Maiden Surname): MICHELLE A. WELLMAN
19a. INFORMANT'S NAME (Type/Print): MICHELLE A. WELLMAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3801 2nd ST. BALTO., MD 21225
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY DATE 4/6/92
20c. LOCATION — City or Town, State: BALTO., MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Stanley Dido
22. NAME AND ADDRESS OF FACILITY: CHARLES L. STEVENS FUNERAL HOME, INC. 1501 E. FORT AVE., BALTO., MD 21230

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Smoke + Soot Inhalation
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO FP
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 03-31-1992
28b. TIME OF INJURY: 1:53PM
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: VICTIM OF HOUSE FIRE
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 3801 2nd ST. BALTO, MD
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Frank J. Peretti MD
29c. LICENSE NUMBER: O.C.M.E
29d. DATE SIGNED (Month, Day, Year): ▶04-01-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK J. PERETTI MD 111 N. PENN ST. BALTIMORE, MARYLAND 21201
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Ratcliffe

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09234
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William H. JEFFERSON
2. DATE OF DEATH (Month, Day, Year): 4 01 92
3. TIME OF DEATH: 0110 A M
4. SOCIAL SECURITY NUMBER: 212-01-5766
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 5/3/16
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY
9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5218 St. Charles Avenue
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+):
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Milton H. Jefferson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Wee
19a. INFORMANT'S NAME (Type/Print): Mr. William F. Jefferson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3526 Hickory Avenue Baltimore, MD 21211
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other piece): Lake View Memorial Park DATE: 4/4/92
20c. LOCATION — City or Town, State: Sykesville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stephen M Jenkins
22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ruptured abdominal aortic aneurysm
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Wm B Horner MD
29c. LICENSE NUMBER: D13053
29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Wm. B. Horner MD
31. DATE FILED (Month, Day, Year): APR 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09235
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hannah Katzen				2. DATE OF DEATH (Month, Day, Year): 4 / 1 / 92	3. TIME OF DEATH: 7:15A M
4. SOCIAL SECURITY NUMBER: 214-03-6691	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 3/4/1910	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 6514 SANZO RD., APT. C (PICKWICK)			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6514 SANZO RD., APT. C		10f. ZIP CODE: 21209	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: AT HOME	
17. FATHER'S NAME (First, Middle, Last): HYMAN WOLFE		18. MOTHER'S NAME (First, Middle, Maiden Surname): EVA GOLDBERG	
19a. INFORMANT'S NAME (Type/Print): MRS. KARLEEN LEVENSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6804 MAURLEEN RD. BALTIMORE, MD 21209	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE HEBREW	DATE: 4/2/92	20c. LOCATION — City or Town, State: REISTERSTOWN, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jay Allan Lewis		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Pancreatic Carcinoma	10 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. —

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Davis M Hahn	29c. LICENSE NUMBER: D20396	29d. DATE SIGNED (Month, Day, Year) ▶ 4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Davis M Hahn 5601 Loch Raven Blvd Balto Md 21239		
31. DATE FILED (Month, Day, Year): APR 03 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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92 09236

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S HAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)			3. TIME OF DEATH
JAMES	MILTON	KING	3	31	1992	11:30P M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
433 16 7891	1 [X] M 2 [ ] F	75 YRS.			04 15 1916	LOUISIANA

9a. FACILITY HAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATIOH OF DEATH	9c. COUNTY OF DEATH
PERRY POINT VA HOSPITAL	PERRY POINT	CECIL

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. IHSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
MD	ANNE ARUNDEL	GLEN BURNIE	
10e. STREET AND HUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?	
979 SHORELAND DRIVE	21061	U.S.A.	

11. MARITAL STATUS 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS OECEDEHT EVER IH U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPAHIC ORIGIH? (Specify Yes or Ho— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] YES 2 [X] HO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIHD OF BUSIHESS/INDUSTRY
Elementary/Secondary (0-12): 9	College (1-4 or 5+): none	LABORER PACKING	CALVERT DISTILLERY

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S HAME (First, Middle, Maiden Surname)
WILLIAM KING	MOLLIE HALL

19a. IHFORMANT'S HAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CLEMENT R. ANTHONY	979 SHORELAND DRIVE GLEN BURNIE, MD 21061

20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AHD DATE OF OISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY	DATE 4-3	20c. LOCATIOH — City or Town, State BROOKLYN PARK, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [signature]	22. HAME AHD ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Lung Cancer	
	DUE TO (OR AS A CONSEQUEHCE OF):	
Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	b.	
	DUE TO (OR AS A COHSEQUEHCE OF):	
	c.	
	DUE TO (OR AS A COHSEQUEHCE OF):	
	d.	

PART II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] HO	24b. WERE AUTOPSY FINDIHGS AVAILABLE PRIOR TO COMPLETIOH OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MAHHER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be datermined	28a. DATE OF IHJURY (Month, Day, Year)	28b. TIME OF IHJURY M	28c. IHJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW IHJURY OCCURED
	28e. PLACE OF IHJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYIHG PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMIHER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGHATURE AND TITLE OF CERTIFIER [signature] MD	29c. LICEHSE NUMBER D37065	29d. DATE SIGNED (Month, Day, Year) ▶ 1 APR 92

30. HAME AHD ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RICHARD FREEMAN M.D., VAMC PERRY POINT MD 21902

31. DATE FILED (Month, Day, Year) APR 3 1992	32. REGISTRAR'S SIGHATURE [signature]

DHMH-16 Rev 1/89

92 09237

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thomas, Kennedy JR.		2. DATE OF DEATH (Month, Day, Year): 3 30 92	3. TIME OF DEATH: 3:25 PM
4. SOCIAL SECURITY NUMBER: 218 18 5414	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 2, 1923
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Baltimore VA Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Dundalk	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1412 Delvale Avenue	10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): supervisor	16b. KIND OF BUSINESS/INDUSTRY: steel industry	
17. FATHER'S NAME (First, Middle, Last): Thomas Kennedy, Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Sophia Tueffer		
19a. INFORMANT'S NAME (Type/Print): Bertha V. Weber	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1412 Delvale Avenue Balto., Md. 21222		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Western Cemetary	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Colt Connelly	22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Maxillary sinus Carcinoma	11mo
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Lower GI bleeding

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28c. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Portelli M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 22 S. Greene St. Baltimore MD		
31. DATE FILED (Month, Day, Year): APR 03 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

N 15

92 09238

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harry W. Leutner, Jr.			2. DATE OF DEATH (Month, Day, Year): 4-1-92	3. TIME OF DEATH: 3:12 A M
4. SOCIAL SECURITY NUMBER: 212-12-0086	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 19, 1919	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Ellicott City	9c. COUNTY OF DEATH: Howard County	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO	
10e. STREET AND NUMBER: 3004 N. Ridge Road Apt. 102		10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner	16b. KIND OF BUSINESS/INDUSTRY: Signcrafters	
17. FATHER'S NAME (First, Middle, Last): Harry W. Leutner, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula E. Smith		
19a. INFORMANT'S NAME (Type/Print): Mrs. Marguerite Leutner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3004 N. Ridge Road Apt. 204 Ellicott City, MD 21043		
20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Mausoleum	20c. LOCATION — City or Town, State: Woodlawn, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John K Ryan		22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIOPULMONARY RESUSCITATION

DUE TO (OR AS A CONSEQUENCE OF):
b. ADVANCED ASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. COPD

DUE TO (OR AS A CONSEQUENCE OF):
d. CHF

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	3D1172	4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] MD 3460 Ellicott Center Dr Suite 103 E.C. MD 21043

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 3 1992	[signature]

DHMH-18 Rev 1/89

92 09239

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ollie McMillion					2. DATE OF DEATH (Month, Day, Year): April 2, 1992	3. TIME OF DEATH: 8:25am M
4. SOCIAL SECURITY NUMBER: 219-22-3100	5. SEX: 1 ☐ M 2 ☒ F XX	6. AGE (In yrs. last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 4-05-24	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore, City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1102 Druid Hill Ave. Apt-710		10f. ZIP CODE: 21217	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced XX	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO XX IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO XX Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): William		18. MOTHER'S NAME (First, Middle, Maiden Surname): Melinda Roddy	
19a. INFORMANT'S NAME (Type/Print): Elise L. McMillion		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1708 E. 30th St. / Baltimore, Md. 21218	

20a. METHOD OF DISPOSITION: 1 ☒ Burial XX 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery	DATE	20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bernard D Johnson		22. NAME AND ADDRESS OF FACILITY: Wm.C. March F/H 1101 E. North Ave.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Carcinoma of the esophagus with metastasis to the liver.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b.	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO XX	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: XX 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)	1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
	2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Peter S. Pham, MD		29c. LICENSE NUMBER: n/a	29d. DATE SIGNED (Month, Day, Year): ▶ 4/2/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter Pham, M.D.		c/o Maryland General Hospital	
31. DATE FILED (Month, Day, Year): APR 3 1992	32. REGISTRAR'S SIGNATURE:		

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09240

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SHIRLEY M MULLINS

2. DATE OF DEATH (Month, Day, Year): 04-01-92

3. TIME OF DEATH: 730p M

4. SOCIAL SECURITY NUMBER: 415123083

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 68 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 8/2/23

8. BIRTHPLACE (State or Foreign Country): GA

9a. FACILITY NAME (If not institution, give street and number): ST JOSEPH HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON

9c. COUNTY OF DEATH: BALT.

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER: 2822 HUNTINGDON AVE

10f. ZIP CODE: 21211

10g. CITIZEN OF WHAT COUNTRY?: US

11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): William Jackson Hayes

18. MOTHER'S NAME (First, Middle, Maiden Surname): Pearl Alexander

19a. INFORMANT'S NAME (Type/Print): Hurley Lee Mullins

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2822 Huntingdon Avenue, Baltimore, Maryland 21211

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Crest Lawn Memorial Park — DATE: 4/6

20c. LOCATION — City or Town, State: Sykesville, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lynn Burgee Henss

22. NAME AND ADDRESS OF FACILITY: Burgee-Henss Funeral Home
3631 Falls Road, Baltimore, Md 21211

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE

DUE TO (OR AS A CONSEQUENCE OF): ISCHEMIC CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: RENAL INSUFFICIENCY

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Francis T. Khoo

29c. LICENSE NUMBER: D30263

29d. DATE SIGNED (Month, Day, Year): 04-01-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANCIS T. KHOO, STAFF MD ST. JOSEPH HOSPITAL

31. DATE FILED (Month, Day, Year): APR 0 3 1992

32. REGISTRAR'S SIGNATURE: June Davidson-Kinsella

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09241

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William J. Moxey
2. DATE OF DEATH (Month, Day, Year): April 3, 1992
3. TIME OF DEATH: 4:20 AM
4. SOCIAL SECURITY NUMBER: 216-07-5308
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 23, 1911
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 3001 Virginia Ave.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3001 Virginia Ave.
10f. ZIP CODE: 21227
10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [ ] YES XXNO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA; College (1-4 or 5+): NA
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plant Supervisor
16b. KIND OF BUSINESS/INDUSTRY: Vinegar Co.
17. FATHER'S NAME (First, Middle, Last): Jacob Moxey
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Era
19a. INFORMANT'S NAME (Type/Print): Marie A. Moxey (Wife)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3001 Virginia Ave., Baltimore, Md. 21227
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) Entombment
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Stanislaus Mausoleum — DATE:
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Chron Obstructive LUNG Disease Emphysema
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d. Metastatic Rectal Carcinoma — 2½ months

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic Cardiovascular Disease, Cerebrovascular Accident

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Russell DeLuca M
29c. LICENSE NUMBER: 031551
29d. DATE SIGNED (Month, Day, Year): 4/3/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Russell DeLuca, Harbor Hospital, 3001 S. Hanover St. Baltimore, Md.
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Tina Davidson-Randall

OHMH-16 Rev 1/89

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92 09242

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Chester M. McKinley
2. DATE OF DEATH — MONTH: 4 DAY: 01 YEAR: 92
3. TIME OF DEATH: 4.30 PM
4. SOCIAL SECURITY NUMBER: 249-03-5834
5. SEX: 1 ☐ M 2 ☐ F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/7/1912
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore MD
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER:
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 6th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): William McKinley
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Page
19a. INFORMANT'S NAME (Type/Print): Jenifer Rucker
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2122 Lakewood Drive. Balto. Md. 21207
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial Park — DATE: 4-6-92
20c. LOCATION — City or Town, State: Balto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Glynis B. Scott
22. NAME AND ADDRESS OF FACILITY: March Funeral Home-West 4300 Wabash Av. Balto. md. 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Carcinoma of stach
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) — 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): ▶ 4/01/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): B. NOLAN, M.D. Good Samaritan Hospital Balt. MD 21239
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

5

92 09243

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alice L. Murdock
2. DATE OF DEATH: MONTH 3 DAY 30 YEAR 92
3. TIME OF DEATH: 10:05 PM
4. SOCIAL SECURITY NUMBER: 212-01-6293
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/24/08
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Augsburg Lutheran Home
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Lochern
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6811 Campfield Road
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Factory Worker and Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Charles Cox
18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Carter
19a. INFORMANT'S NAME (Type/Print): Augsburg Lutheran Home
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6811 Campfield Road Baltimore, MD 21207
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Mem. Park DATE 4/2
20c. LOCATION — City or Town, State: Sykesville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas B. Cover
22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Congestive heart failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Ischemic cardiomyopathy

DUE TO (OR AS A CONSEQUENCE OF):

c. Coronary artery disease

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D37573
29d. DATE SIGNED (Month, Day, Year): 4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 7220 Park Heights Ave. Baltimore MD 21208
31. DATE FILED (Month, Day, Year): APR 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09244

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH A. MULHOLLAND				2. DATE OF DEATH (Month, Day, Year): APRIL 2 1992	3. TIME OF DEATH: 3:15A M
4. SOCIAL SECURITY NUMBER: 215-42-8549	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): AUG 17, 1904	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Charlestown Retirement Community			9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3024 N. Calvert Street		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Personel Director	16b. KIND OF BUSINESS/INDUSTRY: Social Security
17. FATHER'S NAME (First, Middle, Last): James B. Mulholland		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Edgington	
19a. INFORMANT'S NAME (Type/Print): Rosemarie Wright		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Rain Flower Path Unit 204 Sparks Maryland 21152	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert M. Kratz M00344		22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. METASTATIC COLON CANCER
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ANEMIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D40012	29d. DATE SIGNED (Month, Day, Year): 4/2/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
SCOTT POULTON, 711 MAIDEN CHOICE LANE, CATONSVILLE, MD 21228

31. DATE FILED (Month, Day, Year): APR 03 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09245
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mabel Maith
2. DATE OF DEATH (Month, Day, Year): 3 29 92
3. TIME OF DEATH: 8 51 M
4. SOCIAL SECURITY NUMBER: 213-50-4185
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (If yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7. DATE OF BIRTH (Month, Day, Year): 5-17-1898
8. BIRTHPLACE (State or Foreign Country): VA.
9a. FACILITY NAME (If not institution, give street and number): Siani Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4010 Oswego Ct. 21215
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Alfred Stewart
18. MOTHER'S NAME (First, Middle, Maiden Surname): Kate Maith
19a. INFORMANT'S NAME (Type/Print): Lureen Foote
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4010 Oswego Ct. Baltimore, Md. 21215
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Lively Hope Bapt. Cem. DATE: 4-4-92
20c. LOCATION — City or Town, State: CallaoVa.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William C. Brown
22. NAME AND ADDRESS OF FACILITY: William C. Brown Community F/H, 1206 W. North Ave.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death: 1 week

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure
Seizure Disorder

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Glen Rosenfeld MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 3/29/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Glen Rosenfeld M.D. Sinai Hospital of Baltimore, MD
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH-16 Rev 1/89

92 09246

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERNESTO S. MARTINEZ, JR.				2. DATE OF DEATH (Month, Day, Year): 03 31 92	3. TIME OF DEATH: 01:22 PM M
4. SOCIAL SECURITY NUMBER: 459-44-2173	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 4-17-33	8. BIRTHPLACE (State or Foreign Country): TEXAS
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL ASSOCIATION			9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: GLEN BURNIE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1012 THOMAS ROAD		10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: KOREAN	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] YES 2 [ ] NO Specify: MEXICAN	14. RACE — American Indian, Black, White, etc. Specify: MEXICAN

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CUSTOMER SERVICE AGENT	16b. KIND OF BUSINESS/INDUSTRY: TRANS WORLD AIRLINES	
17. FATHER'S NAME (First, Middle, Last): ERNESTO C. MARTINEZ		18. MOTHER'S NAME (First, Middle, Maiden Surname): JUANITA SABEDRA	
19a. INFORMANT'S NAME (Type/Print): MARY E. MARTINEZ		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1012 THOMAS ROAD GLEN BURNIE, MD 21061	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK	DATE: 4-3-92	20c. LOCATION — City or Town, State: GLEN BURNIE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac Arrest	
DUE TO (OR AS A CONSEQUENCE OF): b.	Acute Myocardial Infarction	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Presbitero, MD.	29c. LICENSE NUMBER: D16208	29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSE M. PRESBITERO, M.D./7845 OAKWOOD ROAD, SUITE 100/GLEN BURNIE, MARYLAND 21061

31. DATE FILED (Month, Day, Year): APR 3 1992	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09247
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANTONIO POWERS					2. DATE OF DEATH (Month, Day, Year): MARCH 31, 1992		3. TIME OF DEATH: 8:25a.m. M
4. SOCIAL SECURITY NUMBER: 217-74-7318	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 29 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5-18-62		8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE CITY		

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore, City	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1601 Aisquith Street		10f. ZIP CODE: 21202	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY: State Lumber Yard	
17. FATHER'S NAME (First, Middle, Last): James Powers		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ursula Johnson	
19a. INFORMANT'S NAME (Type/Print): Ursula Powers	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1601 Aisquith St./ Baltimore, Md. 21202		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, Crematory or other place): King Memorial Pk. Cem. DATE	20c. LOCATION — City or Town, State: Randallstown, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bernard D Johnson	22. NAME AND ADDRESS OF FACILITY: Wm.C. March F/H 1101 E. North Ave.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Sepsis	3 d
DUE TO (OR AS A CONSEQUENCE OF): b.	Peritonitis	3 d
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Cirrhosis	4 yr.
d.	Alcohol	15 yr.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Ethic liver disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: D. W. Allen MD	29c. LICENSE NUMBER: E9814	29d. DATE SIGNED (Month, Day, Year): ▶ 7/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David W. Allen, M.D. Johns Hopkins Hospital Baltimore, MD 21205

31. DATE FILED (Month, Day, Year): APR 03 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury as other traumatic event, the medical examiner must be notified at once.

2

92 09248

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William J. E. Powers			2. DATE OF DEATH (Month, Day, Year): April 2 1992	3. TIME OF DEATH: 4 15 PM
4. SOCIAL SECURITY NUMBER: 227-24-6662	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-24-1924	6. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Baltimore City	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 3614 Malden Avenue		10f. ZIP CODE: 21211	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Crain Operator	16b. KIND OF BUSINESS/INDUSTRY: Revere Copper	
17. FATHER'S NAME (First, Middle, Last): Will Powers		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Wallen	
19a. INFORMANT'S NAME (Type/Print): Mrs. Audrey Powers		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3614 Malden Avenue Baltimore, Maryland 21211	

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park	DATE: 4/6	20c. LOCATION — City or Town, State: Dorsey, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Tracey Henss Carpenter		22. NAME AND ADDRESS OF FACILITY: Burgee-Henss Funeral Home 3631 Falls Road Baltimore, Maryland 21211	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	45 min
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute Myocardial Infarction	24 hrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Enrico P. Veltri	29c. LICENSE NUMBER: D28040	29d. DATE SIGNED (Month, Day, Year) ▶ 4/2/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ENRICO P. VELTRI M.D. SINAI HOSPITAL OF BALTIMORE		
31. DATE FILED (Month, Day, Year): APR 0 3 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09249

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rose H. Robl
2. DATE OF DEATH — MONTH: 04 DAY: 02 YEAR: 92
3. TIME OF DEATH: 02:30 A M
4. SOCIAL SECURITY NUMBER: 219-10-7836
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 87 YRS.
IF UNDER 1 YEAR — MONTHS: DAYS: IF UNDER 24 HRS. — HOURS: MIN.:
7. DATE OF BIRTH (Month, Day, Year): Sept. 26, 1904
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: - - - -

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2218 Park Drive
10f. ZIP CODE: 21220
10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): NA — College (1-4 or 5+): NA
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Riveter
16b. KIND OF BUSINESS/INDUSTRY: Martin Marietta
17. FATHER'S NAME (First, Middle, Last): John Hulla
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Svoboda
19a. INFORMANT'S NAME (Type/Print): Louis A. Robl (Son)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4220 Soth Ave., Baltimore, Md. 21236
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory — DATE:
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Homes, Inc. 9705 Belair Road, Baltimore, Md. 21236

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. LYMPHOMA
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. —
DUE TO (OR AS A CONSEQUENCE OF):
c. —
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. —

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Sabah Al-Attar, MD
29c. LICENSE NUMBER: D37725
29d. DATE SIGNED (Month, Day, Year): ▶ 04/02/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sabah Al-Attar, MD, Church Hospital, Baltimore, MD
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

6

92 09250

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VIRGINIA V. RUSSELL			2. DATE OF DEATH (Month, Day, Year): MARCH 31, 1992	3. TIME OF DEATH: 11:20 P M
4. SOCIAL SECURITY NUMBER: 214-38-2291	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-7-40	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 3037 Harlem Ave		10f. ZIP CODE: 21216	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: B

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Computer Programer	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): James Theodore Russell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Jane Williams	
19a. INFORMANT'S NAME (Type/Print): Theodore Russell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 316 Holly Manor Rd Balto, MD. 21228	
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cemetery	DATE: 4-6-92	20c. LOCATION — City or Town, State: Catonsville, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm C. Brown		22. NAME AND ADDRESS OF FACILITY: 1206 W. North Ave William C. Brown Community F.H.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIOMYOPATHY	1 MO
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. METASTATIC BREAST Ca	4 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jill Watanabe MD	29c. LICENSE NUMBER: JHH J8166	29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JILL WATANABE, MD JHH TOWER 110 BALT, MD 21205

31. DATE FILED (Month, Day, Year): APR 03 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

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0-11b-68-83 002 4

92 09251

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Rother, Jr.			2. DATE OF DEATH (Month, Day, Year): Apr.02, 1992	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 705-10-7254	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 88 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)	7. DATE OF BIRTH (Month, Day, Year): 07/28/03	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 5521 Rockleigh Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Arbutus		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: Md	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Arbutus		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10a. STREET AND NUMBER: 5521 Rockleigh Drive		10f. ZIP CODE: 21227		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES: n/a	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: n/a		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): maintanace		16b. KIND OF BUSINESS/INDUSTRY: railroad
17. FATHER'S NAME (First, Middle, Last): Charles Rother, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Walker		
19a. INFORMANT'S NAME (Type/Print): Barbara E. Vogt		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1048 Elm Road Halethorpe Md 21227		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery		20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home 1328 Sulphur Spring Road, Arbutus,Md		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. A Thrombotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Hypertension

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gastritis

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William M Russell MD	29c. LICENSE NUMBER: D 30182	29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William Russell MD 3320 Benson Ave Balt. MD 21227		
31. DATE FILED (Month, Day, Year): APR 0 3 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/69

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09252
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Nollie NOLLIE ELIZABETH ROGERS Rogers
2. DATE OF DEATH (Month, Day, Year): 04 02 92
3. TIME OF DEATH: 01:20A M
4. SOCIAL SECURITY NUMBER: 266-14-5212
5. SEX: 1 ☐ M 2 ☒ F (X)
6. AGE (In yrs. last birthday): 82 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-01-09
8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: none

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: none
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 ☒ YES (X) 2 ☐ NO
10e. STREET AND NUMBER: 1312 N. Broadway
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO (X) IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO (X) Specify:
14. RACE — American Indian, Black, White, etc. Specify: Negroid
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade; College (1-4 or 5 +): none
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Custodian
16b. KIND OF BUSINESS/INDUSTRY: Baltimore City Board of Education
17. FATHER'S NAME (First, Middle, Last): Frank Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): Amelia Smart
19a. INFORMANT'S NAME (Type/Print): Richard Rogers
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1312 N. Broadway, BAltimore, Md. 21213
20a. METHOD OF DISPOSITION: 1 ☒ Burial (X) 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Natl. Mem. Pk. DATE: 4/6/92
20c. LOCATION — City or Town, State: Laurel, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin B. Scruggs Sr.
22. NAME AND ADDRESS OF FACILITY: Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto. Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PNEUMONIA AND SEPSIS (Pneumonia and Sepsis)
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. —
DUE TO (OR AS A CONSEQUENCE OF):
c. —
DUE TO (OR AS A CONSEQUENCE OF):
d. —

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO (X)
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO (X)

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO (X)
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient (X) 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural (X) 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN (X): To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Sabah Al-Attar, MD
29c. LICENSE NUMBER: D37725
29d. DATE SIGNED (Month, Day, Year): ▶ 04/02/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sabah Al-Attar, MD Church Hospital, Baltimore, MD
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

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92 09253

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First Middle, Last): AUDREY MARLENE SMITH			2. DATE OF DEATH MONTH 3 DAY 30 YEAR 92	3. TIME OF DEATH 1500 M
4. SOCIAL SECURITY NUMBER: 214-32-4878	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-8-1935	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 8203 ROSEBANK AVENUE		9b. CITY, TOWN OR LOCATION OF DEATH: DUNDALK		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: DUNDALK	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8203 ROSEBANK AVENUE		10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE; College (1-4 or 5+): N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SEAMSTRESS	16b. KIND OF BUSINESS/INDUSTRY: TAILORING
17. FATHER'S NAME (First, Middle, Last): PAUL W. T. LAMBERT		18. MOTHER'S NAME (First, Middle, Maiden Surname): CORA EVA BLUBAUGH	
19a. INFORMANT'S NAME (Type/Print): THOMAS A. SMITH		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8203 ROSEBANK AVENUE BALTIMORE, MARYLAND 21222	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. PAUL'S LUTHERAN CEM. 4/2/92	20c. LOCATION — City or Town, State: UTICA, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gregory E Reed		22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK MD 21222	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute myocardial infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesterolemia, mild

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Crossan Donovan	29c. LICENSE NUMBER: D07632	29d. DATE SIGNED (Month, Day, Year): ▶ 3-30-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. CROSSAN O'DONOVAN, M.D. 2112 DUNDALK AVE., BALTO., MD. 21222

31. DATE FILED (Month, Day, Year): APR 3 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09254

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): AKA Mildred L. Skirvan / Mildred R. Skirvan
2. DATE OF DEATH (Month, Day, Year): 04 01 92
3. TIME OF DEATH: 09:30A M
4. SOCIAL SECURITY NUMBER: 215-14-9211
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 72 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)
7. DATE OF BIRTH (Month, Day, Year): March 13, 1920
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATN: - - - -

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: - - - -
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3324 Kenyon Ave.
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA; College (1-4 or 5+): NA
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cash Management
16b. KIND OF BUSINESS/INDUSTRY: Bank
17. FATHER'S NAME (First, Middle, Last): Arthur Reynolds
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Thomas
19a. INFORMANT'S NAME (Type/Print): Sandra S. Bogdan (Dghtr)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Huntress Ct., Timonium, Md. 21093
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery — DATE:
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Electro-mechanical Dissociation
DUE TO (OR AS A CONSEQUENCE OF):
b. Extension of Myocardial Infarction.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATN (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: P671
29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92 9 hrs
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 09255

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SIMON FRANCIS SIJAVICIUS (AKA) SAVAGE
2. DATE OF DEATH — MONTH: 4 DAY: 2 YEAR: 92
3. TIME OF DEATH: 7 AM M
4. SOCIAL SECURITY NUMBER: 820-03-2116
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 92 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): NOV. 05, 1899
8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1245 JAMES STREET
10f. ZIP CODE: 21223
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 7th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FURNITURE FINISHER
16b. KIND OF BUSINESS/INDUSTRY: FURNITURE MAKING
17. FATHER'S NAME (First, Middle, Last): CHARLES SIJAVICIUS
18. MOTHER'S NAME (First, Middle, Maiden Surname): ONA UNKNOWN
19a. INFORMANT'S NAME (Type/Print): ANNA MARIE BESNOSKA
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1245 JAMES STREET - BALTIMORE, MD. 21223
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MOST HOLY REDEEMER CEMETERY — DATE: 4/4
20c. LOCATION — City or Town, State: BALTIMORE
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Christopher H. Miller
22. NAME AND ADDRESS OF FACILITY: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Prostate Cancer — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dehydration
Mental Arofenia
Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): ▶ 4/2/92.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. [illegible]
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09256

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Donald N Stein — DONALD NEILL STEIN
2. DATE OF DEATH (Month, Day, Year): April 1 1992
3. TIME OF DEATH: 7:10 PM
4. SOCIAL SECURITY NUMBER: 217-20-8439 — 217-20-8493
5. SEX: 1 XXX M 2 ☐ F
6. AGE (In yrs. last birthday): 66 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-6-25
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital — ST. Joseph Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore Towson
9c. COUNTY OF DEATH: Baltimore Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 XXX YES 2 ☐ NO
10e. STREET AND NUMBER: 1313 Walters Avenue
10f. ZIP CODE: 21239
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 XXX Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XXX YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES XXX NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Coordinator of Counselors
16b. KIND OF BUSINESS/INDUSTRY: Counseling
17. FATHER'S NAME (First, Middle, Last): Walter Michael Stein
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucy Garland Hedges
19a. INFORMANT'S NAME (Type/Print): Jacqueline M Stein
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1313 Walters Avenue Baltimore, Maryland 21239
20a. METHOD OF DISPOSITION: 1 XXX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park — DATE: 4/4/
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis Stephen Xenakis M00640
22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. METASTATIC LUNG CANCER
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 XXX NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 XXX NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 XXX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 XXX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 XXX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael D. Aressel, MD
29c. LICENSE NUMBER: D40547
29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL D. ARESSEL, M.D., ST. JOSEPH HOSPITAL, 7620 YORK ROAD, TOWSON, MD 21204
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09257

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Frank Bertram Scott (Bertram F Scott -)			2. DATE OF DEATH MONTH 3 DAY 31 YEAR 92 (3/31/92)	3. TIME OF DEATH 7:20 AM
4. SOCIAL SECURITY NUMBER 212-09-6995	5. SEX 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year) 10/02/09	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY Anne Arundel	10c. CITY, TOWN OR LOCATION Sherwood Forest	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER 715 Robin Hood Hill		10f. ZIP CODE 21405	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Vice President	16b. KIND OF BUSINESS/INDUSTRY Real Estate Company	
17. FATHER'S NAME (First, Middle, Last) Frank L. Scott		16. MOTHER'S NAME (First, Middle, Maiden Surname) Lucetta Bertram	
19a. INFORMANT'S NAME (Type/Print) Susanne A. Lauffer	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Robin Hood Hill Sherwood Forest, MD 21405		
20a. METHOD OF DISPOSITION 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 4/3	20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ George E. MacNabb	22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., Inc. 299 Frederick Rd. Balto., MD 21228		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiec or reapiretory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive heart failure — DUE TO (OR AS A CONSEQUENCE OF):	4yrs-
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b.	Hypertensive heart disease — DUE TO (OR AS A CONSEQUENCE OF):	17yrs-
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal failure

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER [signature] M.D.	29c. LICENSE NUMBER D12452	29d. DATE SIGNED (Month, Day, Year) ▶ 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 900 Bestgate Rd Annapolis Md. 21401		
31. DATE FILED (Month, Day, Year) APR 0 3 1992	32. REGISTRAR'S SIGNATURE [signature]	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09258 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Julius E. Schloss			2. DATE OF DEATH: MONTH 03 DAY 31 YEAR 92	3. TIME OF DEATH: 4 AM
4. SOCIAL SECURITY NUMBER: 215-01-8683	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1-16-04	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): LEVINDALE		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11 SLADE AVE., APT. 914		10f. ZIP CODE: #21208		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MANUFACTURER		16b. KIND OF BUSINESS/INDUSTRY: CLOTHING
17. FATHER'S NAME (First, Middle, Last): JONAS SCHLOSS		18. MOTHER'S NAME (First, Middle, Maiden Surname): RENA HEINEMAN		
19a. INFORMANT'S NAME (Type/Print): MSR. MARY SCHLOSS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 SLADE AVE., APT. 914 BALTIMORE, MD 21208		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDON PARK	DATE: 4/1/92	20c. LOCATION — City or Town, State: BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellenore Levinson		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASPIRATION PNEUMONIA	1 WEEK
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. UNABLE TO SWALLOW	MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CEREBROVASCULAR ACCIDENT	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
VENTRICULAR ARRYTHMIAS

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) —	28b. TIME OF INJURY — 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO — 28d. DESCRIBE HOW INJURY OCCURED —
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) —	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) —

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A.J. Lucco ATTENDING MD	29c. LICENSE NUMBER: D30951	29d. DATE SIGNED (Month, Day, Year): ▶ 3-31-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.J. LUCCO 2434 W. BELVEDERE AVE BALTIMORE 21215		
31. DATE FILED (Month, Day, Year): APR 03 1992	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall	

DHMH-16 Rev 1/89

92 09259

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEON B. SARKIN			2. DATE OF DEATH (Month, Day, Year): MAR. 31, 1992	3. TIME OF DEATH: 5:43 P. M
4. SOCIAL SECURITY NUMBER: 212-07-8229	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5/1/1912	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 16 STONEHENGE CIR., APT. 11		10f. ZIP CODE: 21208	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MASTER PLUMBER	16b. KIND OF BUSINESS/INDUSTRY: PLUMBING
17. FATHER'S NAME (First, Middle, Last): JACOB SARKIN		18. MOTHER'S NAME (First, Middle, Maiden Surname): ANN UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): CAROLYN SCANLON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16 STONEHENGE CIR., APT. 11, BALTO., MD 21208	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): ANSHE NEILSEN DATE: 4/2/92	20c. LOCATION — City or Town, State: ROSEDALE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ellerson Levinson		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or reepiratory arrest, shock, or haert failura. Liat only one ceuse on each lina.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a.	acute myocardial infarction	1/2 hr
DUE TO (OR AS A CONSEQUENCE OF)		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	arteriosclerotic cardiovascular disease	yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

anemia
Chronic renal failure
depression

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Louis W Miller	29c. LICENSE NUMBER: D0742	29d. DATE SIGNED (Month, Day, Year): 4/6/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Louis Miller MD 4000 Old Ct Rd 21208		
31. DATE FILED (Month, Day, Year): APR 03 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09260
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): OLIVE SHRIVER / Olive TAYLOR Shriver

2. DATE OF DEATH (Month, Day, Year): March 31, 1992

3. TIME OF DEATH: 5:00am M

4. SOCIAL SECURITY NUMBER: 213-20-6579

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 90 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 04 20 1901

8. BIRTHPLACE (State or Foreign Country): VIRGINIA

9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: BALTIMORE

10c. CITY, TOWN OR LOCATION: ARBUTUS

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 5555 ASHBOURNE ROAD

10f. ZIP CODE: 21227

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+): 2

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER

16b. KIND OF BUSINESS/INDUSTRY: OWN HOME

17. FATHER'S NAME (First, Middle, Last): WILLIAM TAYLOR

18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA MAE WHITE

19a. INFORMANT'S NAME (Type/Print): STANLEY H. JONES, SR.

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3109 K WHEATON WAY, ELLICOTT CITY, MD 21043

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDON PARK — DATE: 4-2

20c. LOCATION — City or Town, State: BALTIMORE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ D. Watts

22. NAME AND ADDRESS OF FACILITY: SINGLETON FUNERAL HOME, 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis

DUE TO (OR AS A CONSEQUENCE OF): Multiple decubiti

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atherosclerotic cardiovascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Tarek Salkini MD

29c. LICENSE NUMBER: n/a

29d. DATE SIGNED (Month, Day, Year): ▶ 3/31/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Tarek Salkini, M.D. c/o Maryland General Hospital

31. DATE FILED (Month, Day, Year): APR 3 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09261

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): STEPHANIE M. TROUPE
2. DATE OF DEATH: MONTH 3 DAY 30 YEAR 92
3. TIME OF DEATH: 12P M
4. SOCIAL SECURITY NUMBER: 215 12-0263
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 69 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): B 26 22
8. BIRTHPLACE (State or Foreign Country): U.S MD
9a. FACILITY NAME (If not institution, give street and number): STELLA MARIS HOSPICE
9b. CITY, TOWN OR LOCATION OF DEATH: 2300 DULANEY VALLEY RD TOWSON, MD
9c. COUNTY OF DEATH: BALTO.

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Towson
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2300 Dulaney Valley Road
10f. ZIP CODE: 21204
10g. CITIZEN OF WHAT COUNTRY? U S A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4 or 5+): 2
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales
16b. KINO OF BUSINESS/INDUSTRY: Real Estate
17. FATHER'S NAME (First, Middle, Last): Clarke Murphy
18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Hanlon
19a. INFORMANT'S NAME (Type/Print): Mr. Baker H. Troupe
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7110 Heathfield Road Baltimore, Md. 21212
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Friends Burial Grounds — DATE: 4/2
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: C. Sherman Denny, Jr.
22. NAME AND ADDRESS OF FACILITY: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, MD 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseesee, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory erreet, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Deeth

IMMEDIATE CAUSE (Final disease or condition resulting in deeth) → e. EMPHYSEMA
DUE TO (OR AS A CONSEQUENCE OF):

Sequentisily liet conditions, if eny, leeding to immediete cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. OUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditione contributing to deeth but not reeulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER 15504
29d. DATE SIGNED (Month, Day, Year) ▶ 3.30.92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EDDIE NAHKUDA
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall

DHMH-16 Rev 1/89

24

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09262
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) JOSEPHINE (~~LADY~~) Udris					2. DATE OF DEATH MONTH 4 DAY 1 YEAR 92		3. TIME OF DEATH 709 M
4. SOCIAL SECURITY NUMBER 215-09-6198	5. SEX 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 4-13-14		8. BIRTHPLACE (State or Foreign Country) MD
9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSPITAL CORPORATION			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MD.	10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO	
10e. STREET AND NUMBER 2115 BANK Street			10f. ZIP CODE 21231			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 6th; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER			16b. KIND OF BUSINESS/INDUSTRY National Can Co.	
17. FATHER'S NAME (First, Middle, Last) Joseph RUSZAIA			18. MOTHER'S NAME (First, Middle, Maiden Surname) Aniela PUPA				
19a. INFORMANT'S NAME (Type/Print) JOAN STACHOWIAK			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11807 Reynolds Rd. UPPER FALLS MD.				
20a. METHOD OF DISPOSITION 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. STANISLAUS CEM.		DATE 4/4	20c. LOCATION — City or Town, State BALTO. MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Kathleen Weber			22. NAME AND ADDRESS OF FACILITY DAVID J. WEBER F.H. 401 S. Chester St.				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Respiratory arrest	30 min
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pulmonary embolus	1 hr.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Church

27. MANNER OF DEATH 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) 4/1/92

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☑ NO

28d. DESCRIBE HOW INJURY OCCURRED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Christopher O. Hogan

29c. LICENSE NUMBER 034322

29d. DATE SIGNED (Month, Day, Year) ▶ 4/4/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHRISTOPHER HOGAN DR. C. HOGAN 100N BROADWAY

31. DATE FILED (Month, Day, Year) APR 03 1992

32. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15

92 09263

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PEARL V. VINCENT
2. DATE OF DEATH (Month, Day, Year): 4 2 92
3. TIME OF DEATH: 1425 M
4. SOCIAL SECURITY NUMBER: 227-32-8881
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 92 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-5-1900
8. BIRTHPLACE (State or Foreign Country): Va
9a. FACILITY NAME (If not institution, give street and number): Balto Co General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balto
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4402 Joyce Place
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Albert Wiggins
18. MOTHER'S NAME (First, Middle, Maiden Surname): Irene
19a. INFORMANT'S NAME (Type/Print): Reginald Vincent
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6016 Seamon Rd Richmond, Va 23225
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Vincent Family Cem — DATE: 4-7-92
20c. LOCATION — City or Town, State: Greensville Co. Va
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Portia Elvron
22. NAME AND ADDRESS OF FACILITY: March F. H West, 4300 Wabash Ave

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CVA

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA, DECUBITUS ULCERS, MALNUTRITION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: C. Ravi MD
29c. LICENSE NUMBER: D37333
29d. DATE SIGNED (Month, Day, Year): 4.2.92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. RAVI MD, BCGH, RANDALLSTOWN, MD 21133.
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-00

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gertrude Vasold — Gertrude Regina Vasold
2. DATE OF DEATH (Month, Day, Year): April 1, 1992
3. TIME OF DEATH: 1:50 P M
4. SOCIAL SECURITY NUMBER: 215-01-2590
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 07 06 11
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3603 Hudson Street
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housework
16b. KIND OF BUSINESS/INDUSTRY: At Home
17. FATHER'S NAME (First, Middle, Last): George Goeller
18. MOTHER'S NAME (First, Middle, Maiden Surname): Teresa Goeller
19a. INFORMANT'S NAME (Type/Print): Ambrose L. Vasold
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3603 Hudson St. Balto., Md. 21224
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, other place): Sacred Heart of Jesus Cem — DATE: 4-4-92
20c. LOCATION — City or Town, State: Dundalk, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles D. Zeiler
22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 901 S. Conkling St.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	3 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cholangitis	3 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Biliary Carcinoma	3 months
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: G. Mtanous MD. H.O
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): G. Mtanous, M.D c/o Maryland General Hospital
31. DATE FILED (Month, Day, Year): APR 3 1992
32. REGISTRAR'S SIGNATURE:

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bertha Venie					2. DATE OF DEATH (Month / Day / Year): 3 / 30 / 92	3. TIME OF DEATH: 12:55 P M
4. SOCIAL SECURITY NUMBER: 212-22-4493	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6-3-02	8. BIRTHPLACE (State or Foreign Country): va.
9a. FACILITY NAME (If not institution, give street and number): Community Care Nursing Center			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City			9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT						
10a. STATE: Md.	10b. COUNTY:		10c. CITY, TOWN OR LOCATION: Baltimore City			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 124 W. Franklin St.			10f. ZIP CODE:			10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 000	College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook		16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Alexander Howard			18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Winfield			
19a. INFORMANT'S NAME (Type/Print): Ossie Jackson			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1529 Ellamont St. 21216 Baltimore, Md.			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore National		DATE: 4/7/92	20c. LOCATION — City or Town, State: Balto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm E Brown			22. NAME AND ADDRESS OF FACILITY: William C. Brown Community Funeral Home 1206 W. North Ave.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute myocardial Infarction suspected

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Atherosclerotic heart disease

DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic renal failure

DUE TO (OR AS A CONSEQUENCE OF):
d. Chronic congestive heart failure

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cervical spinal stenosis
Quadriplegia Dementia
severe rheumatoid arthritis, anasarca, Lung mass

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D 30494	29d. DATE SIGNED (Month, Day, Year): ▶ 04/2/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] DESA I MD 5008 4C Rd 2nd Floor Balti MD 21212		
31. DATE FILED (Month, Day, Year): APR 0 3 1992	32. REGISTRAR'S SIGNATURE: Jeria Davidson-Randall	

DHMH-16 Rev 1/89

92 09266

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BEULAH E. WATERS			2. DATE OF DEATH: MONTH 3 - DAY 31 - YEAR 92
3. TIME OF DEATH: M	4. SOCIAL SECURITY NUMBER: 218-22-5691	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 67 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6-7-24	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH:	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2244 CECIL AVENUE	10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STORAGE SUPERVISOR	16b. KIND OF BUSINESS/INDUSTRY: ELITE CLEANERS	
17. FATHER'S NAME (First, Middle, Last): CHARLES THOMPSON	18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH SMITH		
19a. INFORMANT'S NAME (Type/Print): BARBARA VENABLE	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2244 CECIL AVENUE/BALTIMORE, MD 21218		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MD NATIONAL MEM. PARK	DATE:	20c. LOCATION — City or Town, State: LAUREL, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bernard D Johnson	22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H./1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hypertensive, Cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Hyperchlesterenia,
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Willie W. Bivings	29c. LICENSE NUMBER: 027718	29d. DATE SIGNED (Month, Day, Year) ▶ 4/2/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Willie W. Bivings M.D. 1200 Metro Plaza Suite 113 Baltimore

31. DATE FILED (Month, Day, Year): APR 03 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

92 09267

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Claudia F. Williams
2. DATE OF DEATH: MONTH 3 DAY 26 YEAR 92
3. TIME OF DEATH: 8:50 pm
4. SOCIAL SECURITY NUMBER: 212-28-6520
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-30-20
8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): University Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Balto
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balto
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3474 Spelman Road
10f. ZIP CODE: 21225
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indien, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Clayton Sewell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Austin
19a. INFORMANT'S NAME (Type/Print): Betty Keaton
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3474 Spelman Road Balto, Md 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): King Mem Park — DATE: 4-4-92
20c. LOCATION — City or Town, State: Randallstown, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Portia Elron
22. NAME AND ADDRESS OF FACILITY: March F.H. West 4300 Wabash Ave

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel diseese or condition resulting in death) → a. MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury that initieted events resulting in desth) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: DX Hoopes MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 3/26/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09268

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Junius Williams
2. DATE OF DEATH: Month March, Day 30, Year 1992
3. TIME OF DEATH: 3:25 P M
4. SOCIAL SECURITY NUMBER: 227-22-6659
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 5-8-1927
8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1843 W. LOMBARD ST.
10f. ZIP CODE: 21223
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: NOV., 1950 to NOV. 1952
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.):
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): ROBERT WILLIAMS
18. MOTHER'S NAME (First, Middle, Maiden Surname): SALLIE BAKER
19a. INFORMANT'S NAME (Type/Print): ZANITA WILLIAMS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1843 W. LOMBARD ST. BALTO., MD 21223
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): GARRISON FOREST VETERAN CEMETERY | DATE: 4-6-92
20c. LOCATION — City or Town, State: OWINGS MILLS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Glynn B. Scott
22. NAME AND ADDRESS OF FACILITY: MARCH FUNERAL-WEST, 4300 WABASH AVE. BALTO. MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Electromechanical dissociation
DUE TO (OR AS A CONSEQUENCE OF):
b. Chronic obstructive pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H. Honainy
29c. LICENSE NUMBER: N/A
29d. DATE SIGNED (Month, Day, Year): ▶ 3/30/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H. Honainy, M.D. c/o Maryland General Hospital
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Ritchie

DHMN-16 Rev 1/89

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92 09269

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thomas F. White

2. DATE OF DEATH (Month, Day, Year): April 2, 1992

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 219-26-1711

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 53 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 8-25-1938

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): 8341 Hillendale Rd. 21234

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 8341 Hillendale Rd.

10f. ZIP CODE: 21234

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laboner

16b. KIND OF BUSINESS/INDUSTRY: Construction Co.

17. FATHER'S NAME (First, Middle, Last): Stanley F. White

18. MOTHER'S NAME (First, Middle, Maiden Surname): Santa Loretta Bonanno

19a. INFORMANT'S NAME (Type/Print): Mrs. Santa Loretta Steuart

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8341 Hillendale Rd. Balto., Md. 21234

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Cemetery

20c. LOCATION — City or Town, State: Balto., Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jody S Miskimon

22. NAME AND ADDRESS OF FACILITY: Hartley Miller Funeral Home
7527 Harford Rd. Balto., MD. 21234

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic lung Carcinoma — 4 mon.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles Padgett MD

29c. LICENSE NUMBER: D15546

29d. DATE SIGNED (Month, Day, Year): 04/03/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHARLES A. PADGETT, MD, 5601 LOCH RAVEN BLVD. BALTO. MD 21239

31. DATE FILED (Month, Day, Year): APR 3 1992

32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

92 09270

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY, WOLF

2. DATE OF DEATH Month: 4 Day: 2 Year: 1992

3. TIME OF DEATH: 5:12 A.M.

4. SOCIAL SECURITY NUMBER: 212-28-9188

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 87 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 10-22-03

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): MANOR CARE ROSSVILLE

9b. CITY, TOWN OR LOCATION OF DEATH: 6600 Ridge Rd.

9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: BALTIMORE

10c. CITY, TOWN OR LOCATION: ROSSVILLE

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 6600 Ridge ROAD

10f. ZIP CODE: 21237-4298

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): UNKNOWN
College (1-4 or 5+): UNKNOWN

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife/Homemaker

16b. KIND OF BUSINESS/INDUSTRY: N/A.

17. FATHER'S NAME (First, Middle, Last): WILLIAM JOHN KELLY

18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH ALOAF

19a. INFORMANT'S NAME (Type/Print): EDWARD A. WOLF JR

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7610 BRIGHTSIDE AVE. BALTO MD 21237

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SACRED HEART OF JESUS

20c. LOCATION — City or Town, State: BALTO. MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Colt Connelly

22. NAME AND ADDRESS OF FACILITY: CONNELLY FUNERAL HOME OF DUNDALK 7110 Sollers Point ROAD 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Worsening renal failure

DUE TO (OR AS A CONSEQUENCE OF):
c. CHF + non-steroidal drugs + U.T.I

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
b. Cardiac arrhythmias, chronic renal insufficiency

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Malika F. Wasseem

29c. LICENSE NUMBER: D-38754

29d. DATE SIGNED (Month, Day, Year): ▶ 4/2/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MALIKA F. WASEEM. MD, 100 N. BROADWAY. BALTIMORE, MD-21231.

31. DATE FILED (Month, Day, Year): APR 03 1992

32. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John F Jr. WEBER
2. DATE OF DEATH (Month, Day, Year): March 31 1992
3. TIME OF DEATH: 8:45 p M
4. SOCIAL SECURITY NUMBER: 220-10-4656
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): &76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 30,15
8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Gray Manor
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2506 West Woodwell
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): boiler operator
16b. KIND OF BUSINESS/INDUSTRY: General Motors
17. FATHER'S NAME (First, Middle, Last): John Frederick Weber, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Mae Hovermale
19a. INFORMANT'S NAME (Type/Print): Freda Weber
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2506 West Woodwell Balto., Md. 21222
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Belair Memorial Cemet — DATE: 4/4
20c. LOCATION — City or Town, State: Belair, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Colt Connelly
22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ea cardiec or reapiretory errest, ahock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Chronic Lung Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly list conditions, if any, leading to immediete cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditiona contributing to death but not resulting in the underlying ceuse given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO COMPLETION OF CAUSE DF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERREO TO MEOICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF OEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. 2 [ ] MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the ceuse(e) end menner ee stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: 01306
29d. DATE SIGNED (Month, Day, Year): ▶ 3-31-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Emil Miskovsky 9000 Franklin square Drive, Balt., M. D. 21237
31. DATE FILED (Month, Day, Year): APR 0 3 1992
32. REGISTRAR'S SIGNATURE: Lia Davidson-Randall

DHMH-16 Rev 1/89

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92 09272

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Morris K. Yorkman Jr.

2. DATE OF DEATH: MONTH 04 DAY 02 YEAR 92 — 4/2/92

3. TIME OF DEATH: 1040 AM

4. SOCIAL SECURITY NUMBER: 214-14-2084

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 04/11/22

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): The Union Memorial Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH: none

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: none

10c. CITY, TOWN OR LOCATION: Baltimore City

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 4004 Glengyle Avenue

10f. ZIP CODE: 21215

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: 4/10/59-9/30/64

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: X

14. RACE — American Indian, Black, White, etc. Specify: Negroid

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade — College (1-4 or 5+): none

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AirForce

16b. KIND OF BUSINESS/INDUSTRY: United States Government

17. FATHER'S NAME (First, Middle, Last): Morris K. Yorkman, Sr.

18. MOTNER'S NAME (First, Middle, Maiden Surname): Carrie Lightfoot

19a. INFORMANT'S NAME (Type/Print): Tommy Yorkman

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1949 English Drive, Midland, Texas 79705

20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Va. Cem. DATE: 4/7/92

20c. LOCATION — City or Town, State: OwingsMills, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin B. Scruggs Sr.

22. NAME AND ADDRESS OF FACILITY: Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Myocardial Infarction (Myocardial Infarction)

DUE TO (OR AS A CONSEQUENCE OF):
b. Cardigenic shock (Cardigemia Shock)

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. Multisystem Organ Failure (Maltisystem failure) organ

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe PVD

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [X] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year): 4/2/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 201 E. University Prkwy. Balto, Md. 21218

31. DATE FILED (Month, Day, Year): APR 0 3 1992

32. REGISTRAR'S SIGNATURE: [signature]

DHMN-16 Rev 1/89

92 09273

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit ___ should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Changiz Azizi			2. DATE OF DEATH (Month, Day, Year): 3 21 92	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 214-62-4766	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 45 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4 24 46	8. BIRTHPLACE (State or Foreign Country): Iran
9a. FACILITY NAME (If not institution, give street and number): 505 Venice Court		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster		9c. COUNTY OF DEATH: Carroll
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 505 Venice Court		10f. ZIP CODE: 21157		10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): engineer		16b. KIND OF BUSINESS/INDUSTRY: Black & Decker
17. FATHER'S NAME (First, Middle, Last): Eammon Azizi		18. MOTHER'S NAME (First, Middle, Maiden Surname): Masoomeh Golgoon		
19a. INFORMANT'S NAME (Type/Print): Mrs. Deborah Azizi		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 505 Venice Court, Westminster, MD 21157		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Memorial Gardns		20c. LOCATION — City or Town, State: Finksburg, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert K. Pritts, Sr.		22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. lung cancer
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

		24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Park W. Espenschade	29c. LICENSE NUMBER: D01079	29d. DATE SIGNED (Month, Day, Year): ▶ 3/23/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr Park W. Espenschade Westminster Md 21157		
31. DATE FILED (Month, Day, Year): MAR 24 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

92 09274

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Nancy L. Acker

2. DATE OF DEATH (Month, Day, Year): March 23 1992

3. TIME OF DEATH: 7:20 A M

4. SOCIAL SECURITY NUMBER: 219-34-4955

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 53 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Oct. 11, 1938

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): 609 Glynita Circle

9b. CITY, TOWN OR LOCATION OF DEATH: Reisterstown

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Reisterstown

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 609 Glynita Circle

10f. ZIP CODE: 21136

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 9
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): Marion A. Miller

18. MOTHER'S NAME (First, Middle, Maiden Surname): Emily K. Riley

19a. INFORMANT'S NAME (Type/Print): Roger L. Miller

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3011 California Ave. Parkville, Md. 21234

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Memorial Park

20c. LOCATION — City or Town, State: Sykesville, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Brian Powell

22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home 11824 Reisterstown Rd. Reisterstown, Md. 21136

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Wall Infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. COPD

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Raymond A. Nze MD

29c. LICENSE NUMBER: D34184

29d. DATE SIGNED (Month, Day, Year): ▶ 3/24/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Raymond A. Nze, M.D. 7801 York Road Towson, Md. 21204

31. DATE FILED (Month, Day, Year): MAR 24 92

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH 16 Rev 1/89

92 09275

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 5 and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GLADYS G. APPEL					2. DATE OF DEATH (Month, Day, Year): March 12, 1992	3. TIME OF DEATH: 05:48 A M
4. SOCIAL SECURITY NUMBER: 212-24-0389	5. SEX: 1 ☐ M 2 XX	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 05-21-1907	8. BIRTHPLACE (State or Foreign Country): WV
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Center					9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland,	10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 328 Reservoir Avenue		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced XX	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO XX Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): owner	16b. KIND OF BUSINESS/INDUSTRY: grocery store
17. FATHER'S NAME (First, Middle, Last): George W. Rinker		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucy Teets	
19a. INFORMANT'S NAME (Type/Print): Mr. Harry G. Appel		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1023 Lafayette Avenue Cumberland, MD 21502	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Herman Cemetery DATE: 3-14	20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James J. Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cirrhosis of the Liver
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Left Lower Lobe Pneumonia
AIDS ???

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D14865	29d. DATE SIGNED (Month, Day, Year): ▶ 3-13-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Robustiano Barrera Memorial Hospital Medical Building Cumberland, MD. 21502

31. DATE FILED (Month, Day, Year): MAR 17 1992	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

92 09276

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVA BUCKLE				2. DATE OF DEATH (Month, Day, Year): MARCH 4, 1992	3. TIME OF DEATH: 3:05 pM
4. SOCIAL SECURITY NUMBER: 212-16-7432	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)		7. DATE OF BIRTH (Month, Day, Year): March 11, 1911	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): DEER'S HEAD CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY		9c. COUNTY OF DEATH: WICOMICO	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Ridgely	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 1, Box 26		10f. ZIP CODE: 21660	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Assembly Worker	16b. KIND OF BUSINESS/INDUSTRY: Manufacturing	
17. FATHER'S NAME (First, Middle, Last): Acie Tribbitt	18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Hudson Tribbitt		
19a. INFORMANT'S NAME (Type/Print): Leon David Buckle	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 12-E, Ridgely, MD 21660		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Greensboro Cemetery	20c. LOCATION — City or Town, State: Greensboro, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: Fleegle-Helfenbein Funeral Home 106 Sunset Ave., Greensboro, MD 21639		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS WITH GANGRENOUS ULCERS BOTH LOWER EXTREMITIES

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. SEVERE PERIPHERAL VASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPOTHYROIDISM, GI BLEEDING, DUE TO GASTRITIS, ASCVD WITH C.H.F., OLD C.V.A. WITH (L) HEMIPARESIS

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Shrestha MD	29c. LICENSE NUMBER: D16278	29d. DATE SIGNED (Month, Day, Year): ▶ 3.4.92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. SHRESTHA, M.D. DEER'S HEAD CENTER, SALISBURY, MD. 21801

31. DATE FILED (Month, Day, Year): MAR - 9 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09277
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Milton Raymond Breeding
2. DATE OF DEATH (Month, Day, Year): March 13 1992
3. TIME OF DEATH: 3:25 P,M
4. SOCIAL SECURITY NUMBER: 222-05-1281
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 21, 1916
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital at Easton
9b. CITY, TOWN OR LOCATION OF DEATH: Easton
9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Caroline
10c. CITY, TOWN OR LOCATION: Greensboro
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: P.O. Box 52
10f. ZIP CODE: 21639
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 5th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Forklift Operator
16b. KIND OF BUSINESS/INDUSTRY: Crysler Corp.
17. FATHER'S NAME (First, Middle, Last): John Breeding
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Thorp Breeding
19a. INFORMANT'S NAME (Type/Print): Wilson Clough
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 52 Greensboro, MD 21639
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Greensboro Cemetery — DATE: 3-17
20c. LOCATION — City or Town, State: Greensboro, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Meagher Heagle
22. NAME AND ADDRESS OF FACILITY: Fleegle-Heltenbein FH. P.O. Box 160 Greensboro Md. 21639

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Mixed cell lymphoma — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death: 3 months

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: David Smith
29c. LICENSE NUMBER: D39887
29d. DATE SIGNED (Month, Day, Year): ▶ 3/14/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David Smith 509 Idlewild Ave. Easton, MD 21601
31. DATE FILED (Month, Day, Year): MAR 17 92
32. REGISTRAR'S SIGNATURE: Tina Davidson-Randall

DHMH-16 Rev 1/89

5

92 09278

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use by the funeral director. Pages 1 - 4 must be filed with the State Registrar within 72 hours after death and a burial-transit permit, Pages 1 - 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use by the hospital or attending physician.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NORMA JEAN BAYNARD			2. DATE OF DEATH: MONTH 03 DAY 21 1992 YEAR	3. TIME OF DEATH: 10:50 P M
4. SOCIAL SECURITY NUMBER: 008-32-5420	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 48 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): 9-3-43	8. BIRTHPLACE (State or Foreign Country): Vermont
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE CITY
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Aberdeen		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 210 Mayberry Drive Apt 103		10f. ZIP CODE: 21001		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNK — College (1-4 or 5+): UNK	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress-Cook	16b. KIND OF BUSINESS/INDUSTRY: Restaurant		
17. FATHER'S NAME (First, Middle, Last): Joseph Max Niquette		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rita Regina Levesque		
19a. INFORMANT'S NAME (Type/Print): Eric Daniels	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 210 Mayberry Dr. Apt. 103 Aberdeen, MD 21001			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): R. A. Ferris & Co., Inc. — DATE: 3/24	20c. LOCATION — City or Town, State: West Chester, PA		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kirsten A. Unglesbee	22. NAME AND ADDRESS OF FACILITY: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter tha mode of dying, such aa cardiac or raapiratory arrest, ahock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. METASTIC OVARIAN CANCER — DUE TO (OR AS A CONSEQUENCE OF): — SEVERAL Months

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. LIVER FAILURE — DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M Esposito

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year): ▶ 3/21/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARK ESPOSITO Sinai Hospital of Balt, BALTIMORE MD

31. DATE FILED (Month, Day, Year): MAR 23 '92

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

15+1

92 09279

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Bryan, Jr.			2. DATE OF DEATH (Month, Day, Year): March 21 1992	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 147-09-2440	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 5, 1917	8. BIRTHPLACE (State or Foreign Country): New Jersey
9a. FACILITY NAME (If not institution, give street and number): 1942 Sidnee Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Edgewood		9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Edgewood	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1942 Sidnee Drive		10f. ZIP CODE: 21040	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II & Korean	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant	16b. KIND OF BUSINESS/INDUSTRY: Civil Service
17. FATHER'S NAME (First, Middle, Last): William T. Bryan, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Derember	
19a. INFORMANT'S NAME (Type/Print): Mrs. Betty Bryan		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1942 Sidnee Drive Edgewood, Maryland 21040	
20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Highview Memorial Gardens	20c. LOCATION — City or Town, State: Fallston, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kirsten Amy Ingleside		22. NAME AND ADDRESS OF FACILITY: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma Lung	6 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence [✓] Other (Specify) Home	
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William MD.	29c. LICENSE NUMBER: D 32609.	29d. DATE SIGNED (Month, Day, Year): ▶ 3/23/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KAMRUDIN MITHANI MD 703 REVOLUTION ST. HAVRE DE GRACE MD 21078

31. DATE FILED (Month, Day, Year): MAR 23 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Item18,Film686,4/16/92,lt
Per. FH.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09280
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Madeleine M. Bouadana
2. DATE OF DEATH (Month, Day, Year): 03-23-92
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 053-42-5555
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-9-06
8. BIRTHPLACE (State or Foreign Country): France
9a. FACILITY NAME (If not institution, give street and number): H.C.G.H.
9b. CITY, TOWN OR LOCATION OF DEATH: Columbia
9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Howard County
10c. CITY, TOWN OR LOCATION: Columbia
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Lorien Nursing Home
10f. ZIP CODE: 21045
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Domestic
17. FATHER'S NAME (First, Middle, Last): Gabriel Chabrut
18. MOTHER'S NAME (First, Middle, Maiden Surname): ~~Marcelle~~ Hermance D'antigny
19a. INFORMANT'S NAME (Type/Print): Mr. Hubert Bouver
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 980 Warren Drive Westmisnter, MD 21157
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Carroll Cremation Service
DATE: 3/24
20c. LOCATION — City or Town, State: Hampstead, MD, U.S.A.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian K. Haight
22. NAME AND ADDRESS OF FACILITY: Haight Funeral Home (P.O. Box 195) Sykesville, MD 21784 U.S.A.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration pneumonia — DUE TO (OR AS A CONSEQUENCE OF): — 1day

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. end stage dementia, probable alzheimer's years — DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Gastrointestinal bleeding

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Richard Kolodrubetz
29c. LICENSE NUMBER: D31575
29d. DATE SIGNED (Month, Day, Year): ▶ 3/24/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KOLODRUBETZ 9501 Old Annapolis Rd Ellicott City MD 21042
31. DATE FILED (Month, Day, Year): MAR 24 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

ONMN-16 Rev 1/89

92 09281

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DONALD LEWIS BARRETT				2. DATE OF DEATH (Month, Day, Year): March 20 1992	3. TIME OF DEATH: 8:25 AM
4. SOCIAL SECURITY NUMBER: 176-20-2996	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5-27-1929	8. BIRTHPLACE (State or Foreign Country): Oxford, PA
9a. FACILITY NAME (If not institution, give street and number): Perrypoint VA Hospital				9b. CITY, TOWN OR LOCATION OF DEATH: Perryville	9c. COUNTY OF DEATH: Cecil Co.

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Rising Sun	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 506 Dodson Dr.		10f. ZIP CODE: 21911	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Korean War 50-53	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerical	16b. KIND OF BUSINESS/INDUSTRY: oil refining	
17. FATHER'S NAME (First, Middle, Last): James Lewis Barrett		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Brisach	
19a. INFORMANT'S NAME (Type/Print): Susan B. Wood		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 Dodson Dr. Rising Sun, MD 21911	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rosebank Cemetery	DATE: 3-23-92	20c. LOCATION — City or Town, State: Rising Sun, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward L. Collins		22. NAME AND ADDRESS OF FACILITY: Edward L. Collins Funeral Home, Inc. Oxford PA	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetione that ceused the death. Do not enter the moda of dying, euch as cardiec or reepiratory errest, ehock, or heert feilure. List only one cause on eech lina.

Approximate Interval Between Oneet and Death

IMMEDIATE CAUSE (Finel diseese or condition resulting in death) →
a. Melanoma with Multiple Metastasis
OUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in death) LAST
b.
OUE TO (OR AS A CONSEQUENCE OF):
c.
OUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] OOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kam-Ken Leung MD	29c. LICENSE NUMBER: MD 16608	29d. OATE SIGNED (Month, Day, Year): ▶ 3 20 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KAM-KEN LEUNG, M.D., VA Medical Center, Perry Point, MD 21902

31. DATE FILED (Month, Day, Year): MAR 23 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

4 I VA gate

92 09282

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lillian S. Blaine			2. DATE OF DEATH (Month, Day, Year): March 24, 1992	3. TIME OF DEATH: 0005 M
4. SOCIAL SECURITY NUMBER: 211-28-1307	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 103 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 2, 1889	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Laurelwood Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Elkton		9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: PA	10b. COUNTY: Delaware	10c. CITY, TOWN OR LOCATION: Media	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 429 South Middletown Road		10f. ZIP CODE: 19063	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: School System
17. FATHER'S NAME (First, Middle, Last): Harry Scofield		18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen R. Hudson	
19a. INFORMANT'S NAME (Type/Print): Edward Ellison		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27 Red Pump Road - Rising Sun, MD 21911	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 27, 1992		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Calvary Cemetery	20c. LOCATION — City or Town, State: Aston, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ralph E. Hicks		22. NAME AND ADDRESS OF FACILITY: Hicks Home for Funerals, PA 103 West Stockton Street Elkton, MD 21921-5521	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio Respiratory Arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Congestive Heart Failure

DUE TO (OR AS A CONSEQUENCE OF):

c. Arteriosclerotic Heart Disease

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D06181	29d. DATE SIGNED (Month, Day, Year): ▶ 3-24-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph G. Lanzi, M.D. - 721 Bridge Street - Elkton, MD 21921

31. DATE FILED (Month, Day, Year): MAR 24 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09283

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Verna Mae Blakeley

2. DATE OF DEATH — MONTH: March; DAY: 17; YEAR: 92

3. TIME OF DEATH: 5:45 AM

4. SOCIAL SECURITY NUMBER: 215-42-9123

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 56 YRS.

IF UNDER 1 YEAR — MONTHS: ; DAYS: ; IF UNDER 24 HRS. — HOURS: ; MIN.:

7. DATE OF BIRTH (Month, Day, Year): May 16, 1935

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH: ----

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Cecil

10c. CITY, TOWN OR LOCATION: Port Deposit

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 47 Maple Hill Drive

10f. ZIP CODE: 21904

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): Seven Years
College (1-4 or 5+): ----

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

16b. KIND OF BUSINESS/INDUSTRY: ---------

17. FATHER'S NAME (First, Middle, Last): James Johnson

18. MOTHER'S NAME (First, Middle, Maiden Surname): Nessie Wilson

19a. INFORMANT'S NAME (Type/Print): Louis E. Blakeley, Sr.

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 47 Maple Hill Drive, Port Deposit, Maryland 21904

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): West Nottingham Cemetery — DATE: 3/20/92

20c. LOCATION — City or Town, State: Colora, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas M. Patterson, Sr

22. NAME AND ADDRESS OF FACILITY: Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LIVER FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE, Adult respiratory distress syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David Pearse MD

29c. LICENSE NUMBER: D29308

29d. DATE SIGNED (Month, Day, Year): 3/17/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE-OF-DEATH (ITEM 27) (Type, Print): Francis Scott Key Medical Center
David Pearse, M.D., 4949 Eastern Avenue, Baltimore, Maryland 21224

31. DATE FILED (Month, Day, Year): MAR 18 '92

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09284

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Millicent Oliver Boulden				2. DATE OF DEATH (Month, Day, Year): 3/19/92	3. TIME OF DEATH: 10:00 P.M
4. SOCIAL SECURITY NUMBER: 216-07-8712	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 21, 1900	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Devin Haven Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Elkton		9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Elkton	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 511 Delaware Ave.		10f. ZIP CODE: 21921	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES: X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): James Oliver		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Magdalena Stumptner	
19a. INFORMANT'S NAME (Type/Print): Harold M. Boulden		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9208 Saybrook Ave., Silver Spring, MD 20901	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Elkton Cemetery	20c. LOCATION — City or Town, State: Elkton, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward McKeever		22. NAME AND ADDRESS OF FACILITY: Gee Funeral Home, 259 E. Main St., Elkton, MD 21921	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such ea cerdiec or respiretory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia (Aspirated)	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. senile Dementia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Cerebral CVA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. HBVD.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

No emic. No Alcohol
Cirrhosis of Liver.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one). HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, end due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD	29c. LICENSE NUMBER: D04823	29d. DATE SIGNED (Month, Day, Year): 3/20/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JUI Chih HSU, MD 223 West main St. Elkton MD 21921

31. DATE FILED (Month, Day, Year): MAR 20 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

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92 09285

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELEANOR MAE BRADLEY
2. DATE OF DEATH (Month, Day, Year): 3/12/92
3. TIME OF DEATH: 3:45 P M
4. SOCIAL SECURITY NUMBER: 214 07 6629
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7/13/13
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 323 WELSH HILL
9b. CITY, TOWN OR LOCATION OF DEATH: FROSTBURG
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: ALLEGANY
10c. CITY, TOWN OR LOCATION: FROSTBURG
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 323 WELSH HILL
10f. ZIP CODE: 21532
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PERSONNEL MANAGER
16b. KIND OF BUSINESS/INDUSTRY: G. C. MURPHY CO.
17. FATHER'S NAME (First, Middle, Last): HENRY LLOYD
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA MAE BROWN
19a. INFORMANT'S NAME (Type/Print): JANICE MARTIN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 WRIGHT STREET, FROSTBURG, MD 21532
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): FROSTBURG MEMORIAL PARK — DATE: 3/15
20c. LOCATION — City or Town, State: FROSTBURG, MD 21532
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Marion M. Sowers
22. NAME AND ADDRESS OF FACILITY: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet causad tha deeth. Do not enter the mode of dying, euch as cardiac or reepiratory arrest, ehock, or heart failura. List only one cause on aech lina.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel diseese or condition resulting in death) → a. Acute Myocardial Infarction — Minut

OUE TO (OR AS A CONSEQUENCE OF):

Sequentielly liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST

b. Coronary atherosclerosis — Years

OUE TO (OR AS A CONSEQUENCE OF):

c.

OUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.: Prior acute subendocardial myocardial infl 10 days

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: V Mazzacco M
29c. LICENSE NUMBER: D07135
29d. DATE SIGNED (Month, Day, Year): 3-13-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): VICTOR E. MAZZACCO, M.D., 912 SETON DRIVE, CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year): MAR 17 1992
32. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09286

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna Elmira Brinkman				2. DATE OF DEATH: MONTH 03 DAY 15 YEAR 92	3. TIME OF DEATH: 4 [illegible] A M
4. SOCIAL SECURITY NUMBER: 215-20-7028	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (in yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7-6-16	8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): FROSTBURG VILLAGE NURSING HOME			9b. CITY, TOWN OR LOCATION OF DEATH: FROSTBURG		9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: FROSTBURG	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 100 HONEYSUCKLE LANE		10f. ZIP CODE: 21532	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FOOD SERVICE WORKER	16b. KIND OF BUSINESS/INDUSTRY: WASHINGTON COUNTY BOARD OF EDUCATION	
17. FATHER'S NAME (First, Middle, Last): CHARLES E. HERBAUGH		18. MOTHER'S NAME (First, Middle, Maiden Surname): SADIE KITE	
19a. INFORMANT'S NAME (Type/Print): LINDA L. LEMMERT		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 189 ORMOND STREET - FROSTBURG, MD 21532	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): FT. ASHBY CEMETERY	DATE: 3/17/92	20c. LOCATION — City or Town, State: FT. ASHBY, WV
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steady R. Upchurch		22. NAME AND ADDRESS OF FACILITY: GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac failure	2 mo
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerosis	10 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid arthritis
Diverticulosis

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: George Breza MD	29c. LICENSE NUMBER: D12532	29d. DATE SIGNED (Month, Day, Year) ▶ 3/16/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GEORGE BREZA, M.D. - 912 SETON DRIVE, CUMBERLAND, MARYLAND 2 1502

31. DATE FILED (Month, Day, Year): MAR 17 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09287

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD G. BROOKMAN			2. DATE OF DEATH (Month, Day, Year): MARCH 14, 1992	3. TIME OF DEATH: 04:20 M
4. SOCIAL SECURITY NUMBER: 214-07-4800	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 01-28-1907	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND, MD.		9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland,	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 11909 Iris Avenue		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): retired	16b. KIND OF BUSINESS/INDUSTRY: Textile -- Celanese	
17. FATHER'S NAME (First, Middle, Last): George E. Brookman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Alverta Cowgill	
19a. INFORMANT'S NAME (Type/Print): Mrs. Anna Margaret Brookman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11909 Iris Avenue Cumberland, MD 21502	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Crematory or other place): SS Peter Paul Cemetery	DATE: 3-17	20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jane F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MASSIVE CEREBROVASCULAR ACCIDENT	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gary Wagoner MD	29c. LICENSE NUMBER: D22181	29d. DATE SIGNED (Month, Day, Year): ▶ 3-14-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. GARY WAGONER, M.D. 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year): MAR 17 1992	32. REGISTRAR'S SIGNATURE: [illegible]

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DHMH-16 Rev 1/89

92 09288

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elmer P. Brinkman			2. DATE OF DEATH (Month, Day, Year): 3 17 1992	3. TIME OF DEATH: 11:30 PM
4. SOCIAL SECURITY NUMBER: 217-10-4218	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5-26-13	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): FROSTBURG VILLAGE NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: FROSTBURG		9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: FROSTBURG	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 100 HONEYSUCKLE LANE		10f. ZIP CODE: 21532	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MANAGER	16b. KIND OF BUSINESS/INDUSTRY: RETAIL: AUTO PARTS	
17. FATHER'S NAME (First, Middle, Last): PERRY BRINKMAN		18. MOTHER'S NAME (First, Middle, Maiden Surname): LAVINIA MANN	
19a. INFORMANT'S NAME (Type/Print): LINDA LEMMERT	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 189 ORMOND STREET - FROSTBURG, MD 21532		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): FT. ASHBY CEMETERY DATE: 3-20-92	20c. LOCATION — City or Town, State: FT. ASHBY, WV	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Wendy M Zachuck	22. NAME AND ADDRESS OF FACILITY: GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Myocardial Infarction	hrs
DUE TO (OR AS A CONSEQUENCE OF): b.	Congestive Heart Failure	2 yrs
DUE TO (OR AS A CONSEQUENCE OF): c.	Ischemic Coronary Artery Disease	10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul J. Livengood MD	29c. LICENSE NUMBER: D23774	29d. DATE SIGNED (Month, Day, Year): 3/18/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAUL T. LIVENGOOD MD 912 SETON DR. CUMBERLAND MD		
31. DATE FILED (Month, Day, Year): MAR 20 1992	32. REGISTRAR'S SIGNATURE: Jessie Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4

92 09289

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Irene Ola Buckler			2. DATE OF DEATH (Month, Day, Year): March 20, 1992	3. TIME OF DEATH: 1:36 P M
4. SOCIAL SECURITY NUMBER: 557-28-8530	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 8, 1919	8. BIRTHPLACE (State or Foreign Country): N. C.
9a. FACILITY NAME (If not institution, give street and number): Malcolm Grow USAF Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Andrews AFB, MD		9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: La Plata	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 602 Clarks Run Road		10f. ZIP CODE: 20646	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 grades; College (1-4 or 5+): - - -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	16b. KIND OF BUSINESS/INDUSTRY: Census Bureau U.S. Gov't	
17. FATHER'S NAME (First, Middle, Last): Melvin Hyder		18. MOTHER'S NAME (First, Middle, Maiden Surname): Louella Stepp	
19a. INFORMANT'S NAME (Type/Print): Martin W. Buckler		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 602 Clarks Run Rd., La Plata, Md. 20646	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Shepherd Memorial Park	20c. LOCATION — City or Town, State: Hendersonville, N.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J. Ridgely Huntt		22. NAME AND ADDRESS OF FACILITY: The Huntt Funeral HOme, Inc. P.O. Box 156, Waldorf, Md. 20604	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Anterior Wall Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Sudden Cardiac Death	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Karen K. Kerle	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ March 20, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KAREN K. KERLE, Captain, USAF, MC
Malcolm Grow USAF Medical Center
Andrews AFB, MD 20331-5300

31. DATE FILED (Month, Day, Year): MAR 24 92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

92 09290

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frances E. Barnett				2. DATE OF DEATH (Month, Day, Year): 03 22 1992	3. TIME OF DEATH: 12:34 AM
4. SOCIAL SECURITY NUMBER: 218-22-6730	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2/14/1919	8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: LaPlata		9c. COUNTY OF DEATH: Charles

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Pomonkey		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Route 1, Box 89		10f. ZIP CODE: 20640		10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Paul Brooks		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Washington		
19a. INFORMANT'S NAME (Type/Print): Yvonne Hairston		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2816 31st, S.E., Apt B 711, Wash., D.C. 20020		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Un. Meth.	DATE: 3/26/92	20c. LOCATION — City or Town, State: Pomonkey, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leon Thornton		22. NAME AND ADDRESS OF FACILITY: Thornton Funeral Home Rural Route 1, Box 115, Pomonkey, Md. 20640		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial infarction, acute	
DUE TO (OR AS A CONSEQUENCE OF):	b. Hypertensive Cardiovascular disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF):	c. Hypertension	
	d. atherosclerosis	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul E. Pritchett M D	29c. LICENSE NUMBER: D-08370	29d. DATE SIGNED (Month, Day, Year) ▶ 3/22/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul E. Pritchett, M.D. 118 La Grange Ave.P.O. Bx 1317 LaPlata MD. 20626

31. DATE FILED (Month, Day, Year): MAR 24 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09291

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BOBBY OWEN CLARK						2. DATE OF DEATH (Month, Day, Year): March 12 1992	3. TIME OF DEATH: 11:52 AM
4. SOCIAL SECURITY NUMBER: 220-16-7519	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		7. DATE OF BIRTH (Month, Day, Year): Oct 6, 1926	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital at Easton			9b. CITY, TOWN OR LOCATION OF DEATH: Easton			9c. COUNTY OF DEATH: Talbot	
RESIDENCE OF DECEDENT							
10a. STATE: MD	10b. COUNTY: Kent		10c. CITY, TOWN OR LOCATION: Rock Hall			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: Bayside & Cherry Street			10f. ZIP CODE: 21661			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10	College (1-4 or 5+):		16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager & Owner			16b. KIND OF BUSINESS/INDUSTRY: Clarks Store	
17. FATHER'S NAME (First, Middle, Last): William Owen Clark			18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Ashley				
19a. INFORMANT'S NAME (Type/Print): Jane Clark			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Bayside & Cherry St, Rock Hall, MD 21661				
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, crematory or other place): Wesley Chapel Cem. 3/15/92			20c. LOCATION — City or Town, State: Rock Hall, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Larry B. Fellows			22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home, P.A. 413 High Street, Chestertown, MD 21620				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet csused the desth. Do not enter the mode of dying, such ss cerdiec or reepiratory arrest, shock, or heert failure. List only one ceuse on esch line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hepato Renal Syndrome	2wks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Cirrhosis of the Liver	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pseudomonas Pangenerosum - Bt Leg

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
D. Lewis MD	D05874	▶ 3/13/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DONALD T. LEWIS 506 IDLEWILD EASTON Md 21601

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 16 '92	Julia Davidson-Randall

21

DHMH-16 Rev 1/89

92 09292

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Pablo Rodriquez Cosme			2. DATE OF OEATH (Month, Day, Year): March 4th 1992	3. TIME OF OEATH: 6:37P M
4. SOCIAL SECURITY NUMBER: 582-10-2209	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 16, 1928	8. BIRTHPLACE (State or Foreign Country): Puerto Rico
9a. FACILITY NAME (If not institution, give street and number): Kent & Queen Anne's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown,	9c. COUNTY OF OEATH: Kent	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Kent	10c. CITY, TOWN OR LOCATION: (Fairlee) Chestertown	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: R.F.D.#		10f. ZIP CODE: 21620	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] YES 2 [ ] NO Specify: Puerto Rican	14. RACE — American Indian, Black, White, etc. Specify:

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Secondary; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Labor	16b. KIND OF BUSINESS/INDUSTRY: Painter	
17. FATHER'S NAME (First, Middle, Last): Agabito Cosme	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lorienco UNK		
19a. INFORMANT'S NAME (Type/Print): Victor Pachco	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Juana Diaz, Puerto Rico		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sementer Munisipal	DATE	20c. LOCATION — City or Town, State: Juana Diaz Puerto Rico
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kenneth Walley	22. NAME AND ADDRESS OF FACILITY: WALLEY FUNERAL HOME 207 Calvert St. Chestertown, Maryland		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the moda of dying, such es cardiec or respiratory arrest, shock, or haart feilure. List only one ceuse on eech line.

Approximata Interval Between Onset snd Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. acute respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequantisily list conditions, if sny, leeding to immediete cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST
b. end stage chronic obstructive pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. OESCRIBE HOW INJURY OCCUREO
	28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner ee stated.
2 [ ] MEDICAL EXAMINER: On the basie of exemination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(s) end menner ee stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D33514	29d. DATE SIGNED (Month, Day, Year): ▶ 3-4-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael Bienenfeld M.D. Medical Bldg. Chestertown, Maryland 21620

31. DATE FILED (Month, Day, Year): MAR 10 92	32. REGISTRAR'S SIGNATURE: Julie Buchheister

8

OHMH-16 Rev 1/89

92 09293

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALICE I. CORRIGAN
2. DATE OF DEATH (Month, Day, Year): Mar. 10. 1992
3. TIME OF DEATH: 8:10 A.M.
4. SOCIAL SECURITY NUMBER: 217 48 2123
5. SEX: 1 ☐ M 2 ☒ F (Fema)
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): June 14, 1905
8. BIRTHPLACE (State or Foreign Country): Canada
9a. FACILITY NAME (If not institution, give street and number): Magnola Hall Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown, Md.
9c. COUNTY OF DEATH: Kent

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Kent
10c. CITY, TOWN OR LOCATION: ~~Chestertown~~ Still Pond
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: RFD Box # 7
10f. ZIP CODE: 21667
10g. CITIZEN OF WHAT COUNTRY?: USA (Naturalized)
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced (Widowed)
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES: NO
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: NO
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 3
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Registered Nurse
16b. KIND OF BUSINESS/INDUSTRY: Hospitals
17. FATHER'S NAME (First, Middle, Last): ~~James~~ William J. Inglis
18. MOTHER'S NAME (First, Middle, Maiden Surname): Jane Withers
19a. INFORMANT'S NAME (Type/Print): William Corrigan
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RFD Box # 7 Still Pond, Md. 21667
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) (Burial)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Still Pond Cem. — DATE: (3/13/92
20c. LOCATION — City or Town, State: Still POnd, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J Willis Wells
22. NAME AND ADDRESS OF FACILITY: Fellows - Wells, 413 High St. Chestertown, Md. 21620

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. arteriosclerotic heart disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: congestive heart failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D - 33514
29d. DATE SIGNED (Month, Day, Year): Mar 11, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael Bienenfeld, M.D. (D-33514) Chestertown, Md. 21620
31. DATE FILED (Month, Day, Year): MAR 11 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09294

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARLIN CATTERTON		2. DATE OF DEATH (Month, Day, Year): 2-28-92	3. TIME OF DEATH: 9:30 P M
4. SOCIAL SECURITY NUMBER: 213-01-3200	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5-26-15
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Easton	9c. COUNTY OF DEATH: Talbot	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Ridgely	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Rt. 1, Box 193K	10f. ZIP CODE: 21660	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warehouse Foreman	16b. KIND OF BUSINESS/INDUSTRY: Manufacturing	
17. FATHER'S NAME (First, Middle, Last): Owen Catterton	18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Potts Catterton		
19a. INFORMANT'S NAME (Type/Print): Helen E. Carll Catterton	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 193K, Ridgely, MD 21660		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastern Shore Veteran's Cemetery	20c. LOCATION — City or Town, State: Hurlock, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Fleegle-Helfenbein Funeral Home 106 Sunset Ave., Greensboro, MD 21639		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiogenic Shock	6
DUE TO (OR AS A CONSEQUENCE OF): b.	Acute Myocardial infarction	12
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension; Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MCJ Rayasingh M.D	29c. LICENSE NUMBER: D41723	29d. DATE SIGNED (Month, Day, Year): 2/28/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. Christadoss Rayasingh M.D. 403, Marvel Court, Easton		
31. DATE FILED (Month, Day, Year): MAR 4 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09295 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marian Iretta Collison
2. DATE OF DEATH (Month, Day, Year): 02 28 1992
3. TIME OF DEATH: 5:30 P.M.
4. SOCIAL SECURITY NUMBER: 216-18-8928
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 67 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 07 08 1924
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Central Avenue, Rt.1 Box 57C
9b. CITY, TOWN OR LOCATION OF DEATH: Ridgely
9c. COUNTY OF DEATH: Caroline

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Caroline
10c. CITY, TOWN OR LOCATION: Ridgely
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Central Avenue, Rt.1 Box 57C
10f. ZIP CODE: 21660
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 yrs.HS grad; College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker/Food Services
16b. KIND OF BUSINESS/INDUSTRY: School Home/ Cafeteria
17. FATHER'S NAME (First, Middle, Last): Willard Hazel Green
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucy Helen Long
19a. INFORMANT'S NAME (Type/Print): Linda C. Pinder
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1 Box 221, Denton, Maryland 21629
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other piece): Denton Cemetery — DATE: 3/3
20c. LOCATION — City or Town, State: Denton, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randolph L. Moore
22. NAME AND ADDRESS OF FACILITY: Moore Funeral Home, P.A. Drawer B, Denton, Maryland 21629

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Alveolar cell carcinoma of lung	1 yr
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: 039749
29d. DATE SIGNED (Month, Day, Year): 3/9/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 503 Dutchmans Lane Easton MD 21601
31. DATE FILED (Month, Day, Year): MAR 12 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09296

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Byron Cade					2. DATE OF DEATH (Month, Day, Year): 03 11 1992	3. TIME OF DEATH: 8:00 A M
4. SOCIAL SECURITY NUMBER: 215-50-4480	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 46 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 03 08 1946	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 205 South Eighth Street			9b. CITY, TOWN OR LOCATION OF DEATH: Denton			9c. COUNTY OF DEATH: Caroline
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Caroline		10c. CITY, TOWN OR LOCATION: Denton			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 205 South Eighth Street			10f. ZIP CODE: 21629			10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yrs. / College (1-4 or 5+): None			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter & Painter			16b. KIND OF BUSINESS/INDUSTRY: Construction and Painting
17. FATHER'S NAME (First, Middle, Last): Nathan James Cade					18. MOTHER'S NAME (First, Middle, Maiden Surname): Hilda Elnora Reed	
19a. INFORMANT'S NAME (Type/Print): Mary Lou Williams			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 3 Box 89, Denton, Maryland 21629			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Denton Cemetery	DATE: 3/13	20c. LOCATION — City or Town, State: Denton, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randolph P. Moore			22. NAME AND ADDRESS OF FACILITY: Moore Funeral Home, P.A. Drawer B, Denton, Maryland 21629			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gastrointestinal hemorrhage	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. unknown (suspected malignancy, colon)	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
alcohol and tobacco abuse
hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
M.D.	D33768	▶ 3/12/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. CORWIN M.D. P.O. BOX 660 DENTON MD 21629

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 13 92	Gina Davidson-Randall

DHMH-16 Rev 1/89

92 09297

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MILDRED M. CORKRAN				2. DATE OF DEATH (Month, Day, Year): Feb. 21, 1992	3. TIME OF DEATH: 5:30 Am M
4. SOCIAL SECURITY NUMBER: 213-18-8751	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 03/20/21	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Route 2, Box 128			9b. CITY, TOWN OR LOCATION OF DEATH: Denton		9c. COUNTY OF DEATH: Caroline

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Denton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Route 2, Box 128		10f. ZIP CODE: 21629	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+):	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Elmer Stottlemyer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Flossie Stottlemyer	
19a. INFORMANT'S NAME (Type/Print): Charles L. Corkran		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2, Box 128, Denton, MD 21629	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Eastern Shore Vet. Cem	DATE: 24	20c. LOCATION — City or Town, State: Hurlock, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael F. Eskew		22. NAME AND ADDRESS OF FACILITY: Framptom-Hawkins-Eskow Funeral Home P.O.Box 43, Federalsburg, MD 21632	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. NON SMALL CARCINOMA OF LUNG	10 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael A. Moskewicz M.D.	29c. LICENSE NUMBER: D-16609	29d. DATE SIGNED (Month, Day, Year): ▶2/25/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL A. MOSKEWICZ MD. 503 BYRN ST. CAMBRIDGE MD		
31. DATE FILED (Month, Day, Year): MAR 2 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	216

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09298
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elsie Marie Cole

2. DATE OF DEATH (Month, Day, Year): March 20, 1992

3. TIME OF DEATH: 3:55 p M

4. SOCIAL SECURITY NUMBER: 213-20-5749

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 86 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Dec. 26, 1905

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Dulaney Towson Nursing Center

9b. CITY, TOWN OR LOCATION OF DEATH: Towson

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Parkton

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 2508 Mt. Carmel Road

10f. ZIP CODE: 21120

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEOENT'S EOUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 6
College (1-4 or 5 +):

16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Assembler

16b. KIND OF BUSINESS/INDUSTRY: Bendix Corp.

17. FATHER'S NAME (First, Middle, Last): Howard Peregoy

18. MOTHER'S NAME (First, Middle, Maiden Surname): Keziah Thompson

19a. INFORMANT'S NAME (Type/Print): Doris C. Moore

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2500 Mt. Carmel Rd., Parkton, Md. 21120

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Carmel U.M. Ch. Cem — DATE: 03/23/92

20c. LOCATION — City or Town, State: Parkton, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J. Garth Eckhardt

22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel 21102, 3296 Charmil Dr., Manchester, Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: D19166

29d. DATE SIGNED (Month, Day, Year): ▶ 3/23/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Alan Baldanza 10629 York RD Cockeysville, MD 21030

31. DATE FILED (Month, Day, Year): MAR 24 '92

32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DHMH-16 Rev 1/89

92 09299

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
David L. Creswell, Sr.	March 19, 1992	0050 M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
215-30-6678	1 [X] M 2 [ ] F	57 YRS.			April 22, 1934	Elkton, Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Devine Haven Nursing Home	Elkton	Cecil

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Cecil	Elkton	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
285 Hollingsworth Manor	21921	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES 8-1-51 - 12-10-53	1 [ ] YES 2 [X] NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Tool Repairman	Aluminum Fabricating

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Charles A. Creswell	Margaret E. McDowell

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Norma G. Rinkerman	285 Hollingsworth Manor - Elkton, MD 21921

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
March 21, 1992 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Gilpin Manor Memorial Park	Elkton, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Donald S. Hicks	Hicks Home for Funerals, PA 103 West Stockton Street Elkton, MD 21921-5521

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cirrhosis Liver	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 [ ] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Sachdev S	D23322	▶ 3/23/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
S.S. Sachdev, M.D. - 118 North Street, Suite 3 B - Elkton, MD 21921

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 24 '92	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Virginia Elizabeth Crouse				2. DATE OF DEATH (Month / Day / Year): 3 / 16 / 92	3. TIME OF DEATH: 1:08 AM
4. SOCIAL SECURITY NUMBER: 233-52-6221	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10/9/1919	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): 163 Basil Ave.			9b. CITY, TOWN OR LOCATION OF DEATH: S. Chesapeake City		9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: S. Chesapeake City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 163 Basil Ave.	10f. ZIP CODE: 21915		10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7yrs; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Arnold McReynolds		18. MOTHER'S NAME (First, Middle, Maiden Surname): Allie Schrader	
19a. INFORMANT'S NAME (Type/Print): Eulas R. Crouse-husb.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 163 Basil Ave S. Chesapeake City, MD 21915		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hockessin Crematory	20c. LOCATION — City or Town, State: Hockessin, DE.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Frank C. Mayer, Jr. FRANK C. MAYER, JR.	22. NAME AND ADDRESS OF FACILITY: Spicer-Mullikin Fnl Homes, Inc N. DuPont Pkwy, New Castle, DE.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	3 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Widely Metastatic Cervical Cancer	3 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
H. Farkas, MD	D15314	▶ 3/16/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Northern Chesp. Hospice
Henry Farkas MD 111 Howard Street Elkton, md 21921

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 19 '92	Julia Davidson-Randall

OHMH-16 Rev 1/89

6

92 09301

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MACON J. COLEMAN			2. DATE OF DEATH (Month, Day, Year): 03-18-1992	3. TIME OF DEATH: 8:30 P. M
4. SOCIAL SECURITY NUMBER: 705-09-9462	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 05-15-1898	8. BIRTHPLACE (State or Foreign Country): NC
9a. FACILITY NAME (If not institution, give street and number): Cumberland Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: Allegany	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland,	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 526 Haddon Avenue		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): retired machinist	16b. KIND OF BUSINESS/INDUSTRY: B & O Railroad	
17. FATHER'S NAME (First, Middle, Last): John H. Coleman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Betty Walker	
19a. INFORMANT'S NAME (Type/Print): Rev. M. Brent Coleman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1818 Lang Drive Crofton, MD 21114	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park 3-21	20c. LOCATION — City or Town, State: Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John J. Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of Prostate	Months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D33280	29d. DATE SIGNED (Month, Day, Year): ▶ 3/19/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Gupta, M.D., Cumberland, MD 21502		
31. DATE FILED (Month, Day, Year): MAR 20 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92-09302

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ruth Ellen DODGE						2. DATE OF DEATH (Month, Day, Year): April 4, 1992	3. TIME OF DEATH: 9:15 P M
4. SOCIAL SECURITY NUMBER: 232-66-1811	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		7. DATE OF BIRTH (Month, Day, Year): May 2, 1920	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Garrett County Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Oakland			9c. COUNTY OF DEATH: Garrett	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Garrett	10c. CITY, TOWN OR LOCATION: Oakland	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 2, Box 5566		10f. ZIP CODE: 21550	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurse's Aid	16b. KIND OF BUSINESS/INDUSTRY: Hospital	
17. FATHER'S NAME (First, Middle, Last): Elijah ----- Frantz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha ----- Hoff	
19a. INFORMANT'S NAME (Type/Print): Ronald E. Dodge		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2, Box 5566, Oakland, Maryland 21550	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Terra Alta Cemetery	DATE: 4/7	20c. LOCATION — City or Town, State: Terra Alta, West VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bradley A. Stewart		22. NAME AND ADDRESS OF FACILITY: StewartFuneral Home 32 S. Second St., oakland, MD 21550	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary Edema	Hours
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CHF	48 Hours
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Hypertensive Cardiovascular Disease	Years
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO NA

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D15333	29d. DATE SIGNED (Month, Day, Year): ▶ 4/4/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Thomas Johnson, MD 311 N. Fourth St., oakland, MD 21550		
31. DATE FILED (Month, Day, Year): APR 9 1992	32. REGISTRAR'S SIGNATURE	

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OHMH-16 Rev 1/89

92 09303

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louis Clayton Dennison			2. DATE OF DEATH: MONTH 3 DAY 14 YEAR 92	3. TIME OF DEATH: 10 45 AM
4. SOCIAL SECURITY NUMBER: 214-01-3662	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 100 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-29-1891	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Frostburg Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Frostburg	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 154 Frost Avenue		10f. ZIP CODE: 21532	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Miner	16b. KIND OF BUSINESS/INDUSTRY: Coal Mines	
17. FATHER'S NAME (First, Middle, Last): Randolph Dennison		18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Race	
19a. INFORMANT'S NAME (Type/Print): Gladys Ewing	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 148 Frost Ave., Frostburg, Md. 21532		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Frostburg Memorial Park DATE 3/17	20c. LOCATION — City or Town, State: Frostburg, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Horn	22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Renal failure	1 month
DUE TO (OR AS A CONSEQUENCE OF): b.	Dehydration	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Congestive Heart failure	1 month
d.	Chronic obstructive lung disease	15 yrs

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D15463	29d. DATE SIGNED (Month, Day, Year): 3/16/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, print): S. Kim, M.D., 70 Main St., Westernport, Md. 21562		
31. DATE FILED (Month, Day, Year): MAR 18 1992	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall	

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DHMH-16 Rev 1/89

92 09304

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elva M. Elliott					2. DATE OF DEATH (Month, Day, Year): 3 9 92		3. TIME OF DEATH: 5:26 a M
4. SOCIAL SECURITY NUMBER: 219-07-6715	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug 18, 1909		8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Easton			9c. COUNTY OF DEATH: Talbot	
RESIDENCE OF DECEDENT							
10a. STATE: MD	10b. COUNTY: Q.A.		10c. CITY, TOWN OR LOCATION: Chestertown			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: RT 1			10f. ZIP CODE: 21620			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress			16b. KIND OF BUSINESS/INDUSTRY: Leeds	
17. FATHER'S NAME (First, Middle, Last): Walter W. Johnson					18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Thomas		
19a. INFORMANT'S NAME (Type/Print): Betty Audrey Bratcher			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt.1, Box 473, Chestertown, MD 21620				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Pleasant Cemetery	DATE: Mar. 13, 1992	20c. LOCATION — City or Town, State: Pondtown, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L Fellows			22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home, P.A. 370 W. Cypress St., Millington, MD 21651				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pancreatitis	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Poss Occult Malignancy	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GI Bleeding
ASCVD

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
D Bowen MD	D05874	▶ 3/9/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DONALD BOWEN MD 306 IDLEWILD EASTON MD 21601

31. DATE FILED (Month, Day, Year)	
MAR 16 92	

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DHMH-16 Rev 1/89

92 09305

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dora E. Eggers					2. DATE OF DEATH (Month, Day, Year): 3-15-92	3. TIME OF DEATH: 2100 P M
4. SOCIAL SECURITY NUMBER: 179-22-1452	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 93 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 4, 1899	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Union Hospital of Cecil County					9b. CITY, TOWN OR LOCATION OF DEATH: Elkton	9c. COUNTY OF DEATH: Cecil
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Cecil				10c. CITY, TOWN OR LOCATION: Elkton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 22 Malvern Drive					10f. ZIP CODE: 21921	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES				13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5 / College (1-4 or 5+)					16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Monroe Vannoy					18. MOTHER'S NAME (First, Middle, Maiden Surname): Charity Lunsford	
19a. INFORMANT'S NAME (Type/Print): Raymond B. Eggers					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2329 Pulaski Highway - Newark, DE 19702	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Union Hill Cemetery — DATE: 3-19-1992	20c. LOCATION — City or Town, State: Kennett Square, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald S. Hicks					22. NAME AND ADDRESS OF FACILITY: Hicks Home for Funerals, PA 103 West Stockton Street Elkton, MD 21921-5521	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raapiratory arreat, ahock, or haart failura. Liat only one cause on aach lina.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute myocard Infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ASCVD
DUE TO (OR AS A CONSEQUENCE OF):
c. Old CVA
DUE TO (OR AS A CONSEQUENCE OF):
d. Hypertension

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
acute dehydration from acute gastroenteritis
No smoking

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Jui-min Hsu MD	D04823	▶ 3/19/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Jui Chih Hsu MD 223 West main St- Elkton, MD 21921

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 19 '92	Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09306

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Calvin Medford Foster, Jr.			2. DATE OF DEATH: MONTH 3 DAY 9 YEAR 92	3. TIME OF DEATH: 1208 P. M
4. SOCIAL SECURITY NUMBER: 217-64-0144	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 37 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 13, 1954	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Union Hospital of Cecil County		9b. CITY, TOWN OR LOCATION OF DEATH: Elkton		9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Cecilton	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 10 Budds Landing Road		10f. ZIP CODE: 21913	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Landscaping	16b. KIND OF BUSINESS/INDUSTRY: Lawn Care	
17. FATHER'S NAME (First, Middle, Last): Calvin M. Foster		18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances L. [redacted] Schuyler	
19a. INFORMANT'S NAME (Type/Print): Frances Pippin		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as above	
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE ANO OATE OF DISPOSITION (Name of cemetary, crematory or other place): Zion Cemetery DATE: 3/12/92	20c. LOCATION — City or Town, State: Cecilton, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Chris D Fellows		22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home, P.A. 370 W. Cypress St., Millington, MD 21651	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or reepiretory erreet, shock, or haert feilure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gun shot wound of head — DUE TO (OR AS A CONSEQUENCE OF):	2 hrs.
Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. — DUE TO (OR AS A CONSEQUENCE OF):	
	c. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Drug + alcohol addictions

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatiant 2 [X] ER/Outpatiant 3 [ ] DOA
OTHER: 4 [ ] Nursing Nome 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATN: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 3/9/92

28b. TIME OF INJURY: 1040 M

28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO

28d. DESCRIBE HOW INJURY OCCURED: Shot himself

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): At home

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 167 Mount Pleasant Rd Cecilton MD

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [redacted] MD

29c. LICENSE NUMBER: [redacted] D12192

29d. DATE SIGNED (Month, Day, Year): ▶ 3/9/92

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): MAR 16 '92

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09307

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page S should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Abraham Martin Feeser			2. DATE OF DEATH (Month, Day, Year): 3 20 92	3. TIME OF DEATH: 0852 A M
4. SOCIAL SECURITY NUMBER: 219-12-1260	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 68 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 12 17 23	8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: Baltimore		

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 824 Littlestown Pike	10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: U.S.	
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarlo Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): worker in receiving	16b. KIND OF BUSINESS/INDUSTRY: (publishing company) Random House	
17. FATHER'S NAME (First, Middle, Last): Milton E. Feeser	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lola Shaffer		
19a. INFORMANT'S NAME (Type/Print): Mrs. Doris Feeser	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 824 Littlestown Pike, Westminster, MD 21157		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bixler's Church Cem. DATE: 3/23	20c. LOCATION — City or Town, State: Westminster, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert K. Pritts, Sr.	22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Status Epilepticus	4 days.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypotension	7-10 days.
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Chronic Renal Failure	
DUE TO (OR AS A CONSEQUENCE OF):		
	d. Atherosclerotic Heart Dx , R/O Sepsis.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: S/P (L) Femoral-Distal Bypass Surgery.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 3-20-92.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): MAR 23 '92	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

OHMH-16 Rev 1/89

92 09308

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Virginia Louise Frizzell			2. DATE OF DEATH (Month, Day, Year): 3 19 92	3. TIME OF DEATH: 1700 M
4. SOCIAL SECURITY NUMBER: 159-22-9142	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8 22 27	8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): Carroll County Gen. Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster		9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Finksburg	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 1875 Deer Park Road		10f. ZIP CODE: 21048	10g. CITIZEN OF WHAT COUNTRY?: U.S.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): worker/inventory	16b. KIND OF BUSINESS/INDUSTRY: Random House publishing company	
17. FATHER'S NAME (First, Middle, Last): Ira Miller		18. MOTHER'S NAME (First, Middle, Maiden Surname): Olive Fonner	
19a. INFORMANT'S NAME (Type/Print): Sandra L. Frizzell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1861 Old Westminster Pike, Westminster, MD	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Deer Park Cemetery 3/23	20c. LOCATION — City or Town, State: Westminster, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert K. Pritts, Sr.		22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Ovarian Cancer — Six month
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D 36147	29d. DATE SIGNED (Month, Day, Year): ▶ 3·21·92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 217 Washington Heights Medical Center, Westminster MD		
31. DATE FILED (Month, Day, Year): MAR 23 '92	32. REGISTRAR'S SIGNATURE: Jacqueline Davidson-Randall	

DHMH-16 Rev 1/89

92 09309

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen M Focht Helen M. Focht			2. DATE OF DEATH: MONTH 3 DAY 13 YEAR 92	3. TIME OF DEATH: 8:05 PM
4. SOCIAL SECURITY NUMBER: 217 07 1093	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 06-20-07	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Columbia		9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9884 Old Annapolis Rd		10f. ZIP CODE: 21042	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Edward Leonard		18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Glos	
19a. INFORMANT'S NAME (Type/Print): Conrad J. Focht		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9884 Old Annapolis Rd Ellicott City MD 21042	

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park	DATE: 3/17/92	20c. LOCATION — City or Town, State: Balt.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry H. Witzke		22. NAME AND ADDRESS OF FACILITY: Harry H Witzke Funeral Home 21043 4112 Old Columbia Pike Ellicott City MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. acute myocardial infarction	12 hrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gary Berg, M.D.	29c. LICENSE NUMBER: D 30928	29d. DATE SIGNED (Month, Day, Year): ▶ 3/13/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GARY BERG, M.D. TWO KNOLL NORTH DR. COLUMBIA, MD 21045

31. DATE FILED (Month, Day, Year): MAR 16 '92	32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall

DHMH-16 Rev 1/89

92 09310

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES LEVERNE FYE

2. DATE OF DEATH (Month, Day, Year): March 16 1992

3. TIME OF DEATH: 1:00 PM

4. SOCIAL SECURITY NUMBER: 179-26-4077

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 57 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.:

7. DATE OF BIRTH (Month, Day, Year): July 12, 1934

8. BIRTHPLACE (State or Foreign Country): Pennsylvania

9a. FACILITY NAME (If not institution, give street and number): V.A. Medical Center

9b. CITY, TOWN OR LOCATION OF DEATH: Perry Point

9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Pennsylvania

10b. COUNTY: Lancaster

10c. CITY, TOWN OR LOCATION: Lancaster

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 215 Pheasant Ridge

10f. ZIP CODE: 17603

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: Korean Conflict

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): Twelve Years
College (1-4 or 5+): ----

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter

16b. KIND OF BUSINESS/INDUSTRY: Construction

17. FATHER'S NAME (First, Middle, Last): Charles Clifford Fye

18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice M. Genstzler

19a. INFORMANT'S NAME (Type/Print): Alice M. Denlinger

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 215 Pheasant Ridge, Lancaster, PA 17603

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Millersville MennoniteCem. DATE: 3/20/92

20c. LOCATION — City or Town, State: Millersville, Pennsylvania

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lee A. Patterson, Sr.

22. NAME AND ADDRESS OF FACILITY: Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Brain Stem Stroke

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER: MD-041463-E

29d. DATE SIGNED (Month, Day, Year): 3/17/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PROMILA SURI, M.D., VA Medical Center, Perry Point, MD 21902

31. DATE FILED (Month, Day, Year): MAR 18 '92

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

8
+1 VA
grads

92 09311

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES W. FISHER
2. DATE OF DEATH (Month, Day, Year): 03-20-92
3. TIME OF DEATH: 4:30 P. M
4. SOCIAL SECURITY NUMBER: 217-10-6273
5. SEX: 1 XX M 2 ☐ F
6. AGE (In yrs. last birthday): 72 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)
7. DATE OF BIRTH (Month, Day, Year): 09-09-1919
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 520 Dryer Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Cumberland
10d. INSIDE CITY LIMITS? XX 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 520 Dryer Avenue
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEOENT'S EOUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): self employed
16b. KIND OF BUSINESS/INOUSTRY: Home Improvement
17. FATHER'S NAME (First, Middle, Last): Edward Fisher
18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Zapf
19a. INFORMANT'S NAME (Type/Print): Mrs. Susan Davis
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15300 Davis Lane Rawlings, MD 21557
20a. METHOD OF OISPOSITION: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Burial Park — DATE: 3/23
20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jon 7 Scarpelli
22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Oneat and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Hypertensive Cardio Vascular Heart Disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D09157
29d. DATE SIGNED (Month, Day, Year): ▶ 3/21/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): Dr. Paul Snow, Dpty Med Ex. 124 W. Third Street, Cumberland, MD 21502
31. DATE FILED (Month, Day, Year): MAR 23 1992
32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

92 09312

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
SYLVIA	K.	GUTTERMAN	3 - 11 - 1992	9:57AM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
119-10-9042	1 ☐ M 2 ☒ F	74 YRS.			1 - 13 - 1918	NEW YORK

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
HOLY CROSS HOSPITAL	SILVER SPRING	MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	MONTGOMERY	ROCKVILLE	1 XX YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
12810 EVANSTON STREET	20853	UNITED STATES

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 XX NO	1 ☐ YES 2 ☒ NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	5	TEACHER	EDUCATION

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
LOUIS KOFFER	NETTIE SILVERSTEIN

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BENJAMIN GUTTERMAN (HUSBAND)	12810 EVANSTON STREET, ROCKVILLE, MARYLAND 20853

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	JUDEAN MEMORIAL GARDENS	3/13	OLNEY, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ [signature]	DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD. 20852

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio vascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D085746	▶ 3-11-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DR. JOHN F. TAUBER - 8218 WISCONSIN AVENUE, BETHESDA, MARYLAND 20814

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 12 '92	[signature]

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09313
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Shirley Elizabeth Griffith

2. DATE OF DEATH (Month, Day, Year): 3 / 18 / 92

3. TIME OF DEATH: 7:57 M

4. SOCIAL SECURITY NUMBER: 220-22-4481

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 76 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 12 31 15

8. BIRTHPLACE (State or Foreign Country): MD

9a. FACILITY NAME (If not institution, give street and number): Carroll County Gen. Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Westminster

9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: Carroll

10c. CITY, TOWN OR LOCATION: Westminster

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER: 2257 Old Taneytown Pike

10f. ZIP CODE: 21158

10g. CITIZEN OF WHAT COUNTRY?: U.S.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

16b. KIND OF BUSINESS/INDUSTRY: n/a

17. FATHER'S NAME (First, Middle, Last): Howard Yeakel

18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Dorsey

19a. INFORMANT'S NAME (Type/Print): S. Regina Wineke

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2259 Old Taneytown Road

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. John Cemetery 3/21

20c. LOCATION — City or Town, State: Westminster, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert K. Pritts, Sr.

22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel
412 Washington Rd., Westminster, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Embolus

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. _____ DUE TO (OR AS A CONSEQUENCE OF):

c. _____ DUE TO (OR AS A CONSEQUENCE OF):

d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard M. Jones, MD

29c. LICENSE NUMBER: D05905

29d. DATE SIGNED (Month, Day, Year): ▶ 19 Mar 92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Jones, M.E. Carroll County General Hospital, Westminster, MD

31. DATE FILED (Month, Day, Year): MAR 23 '92

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09314

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John E. Gormley — John Edward Gormley
2. DATE OF DEATH: MONTH 03 DAY 21 YEAR 92
3. TIME OF DEATH: 12:15 P M
4. SOCIAL SECURITY NUMBER: 577-09-6130
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 07-21-1905
8. BIRTHPLACE (State or Foreign Country): Washington DC
9a. FACILITY NAME (If not Institution, give street and number): Charlotte Hall Veterans HOme
9b. CITY, TOWN OR LOCATION OF DEATH: Charlotte Hall
9c. COUNTY OF DEATH: St. Mary,s

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: St. Mary,s
10c. CITY, TOWN OR LOCATION: Charlotte Hall
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: ROUTE 5 BOX 2
10f. ZIP CODE: 20622
10g. CITIZEN OF WNAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Public Relations
16b. KIND OF BUSINESS/INDUSTRY: Utility
17. FATNER'S NAME (First, Middle, Last): UNKNOWN
18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN
19a. INFORMANT'S NAME (Type/Print): Willie C. Gormley
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14220 Twig Rd. Silver Spring, MD 20905
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stala 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Huntt Crematory
20c. LOCATION — City or Town, State: Waldorf, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stanley C. Echols III
22. NAME AND ADDRESS OF FACILITY: Arehart Funeral Home, Inc. P.O. Box 567 La Plata, MD 20646

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such sa cardiac or respiratory arrest, ehock, or heart feilure. List only one ceuse on eech line.

		Approximata Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Metastasis of Prostate Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Intraventrical Hemorrhage, SVA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATN (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATN: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER: D 39522
29d. DATE SIGNED (Month, Day, Year): ▶ March 21, 1992
30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): MAR 23 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

ONMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09315

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Martha Agnes Grove (MARTHA AGNES GROVE)

2. DATE OF DEATH Month: 3 Day: 20 Year: 92

3. TIME OF DEATH: 11:38 PM

4. SOCIAL SECURITY NUMBER: 212-26-0619

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 91 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 3-16-01

8. BIRTHPLACE (State or Foreign Country): Pennsylvania

9a. FACILITY NAME (If not institution, give street and number): FALLSTON GENERAL HOSP.

9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON

9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Harford

10c. CITY, TOWN OR LOCATION: Joppa

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 2802 W. Franklinville Road

10f. ZIP CODE: 21085

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

16b. KIND OF BUSINESS/INDUSTRY: Home

17. FATHER'S NAME (First, Middle, Last): Levi -- Wilson

16. MOTHER'S NAME (First, Middle, Maiden Surname): Harriet -- Stitt

19a. INFORMANT'S NAME (Type/Print): Donna M. Hicks

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2802 Franklinville Road, Joppa, Md. 21085

20a. METHOD OF DISPOSITION ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park Cem.

20c. LOCATION — City or Town, State: 3-23-92. Baltimore, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K. McComas III

22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest / Stand still

DUE TO (OR AS A CONSEQUENCE OF): Massive myocardial inf

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF): BOUD

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal failure, CHF,

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Attending M.D

29c. LICENSE NUMBER: D 16444

29d. DATE SIGNED (Month, Day, Year): 3-21-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V. S. NAIR M.D 2112 Bel air Road - Fallston MD 21047

31. DATE FILED (Month, Day, Year): MAR 23 '92

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09316

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Clifton Benge Hickman			2. DATE OF DEATH (Month, Day, Year): March 7, 1992	3. TIME OF DEATH: 12:22 A M
4. SOCIAL SECURITY NUMBER: 213-03-4752	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov 21, 1916	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Kent and Queen Annes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown		9c. COUNTY OF DEATH: Kent

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Kent	10c. CITY, TOWN OR LOCATION: Millington	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10a. STREET AND NUMBER: Rt 291, Box 312		10f. ZIP CODE: 21651	10g. CITIZEN OF WHAT COUNTRY?: Millington

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Store manager	16b. KIND OF BUSINESS/INDUSTRY: retail sales	
17. FATHER'S NAME (First, Middle, Last): Robert Paige Hickman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Cecilia Harbeson	
19a. INFORMANT'S NAME (Type/Print): Ida Hickman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as above		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Wesley Chapel Cem	DATE: 3/10/92	20c. LOCATION — City or Town, State: Rock Hall, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mary B Fellows		22. NAME AND ADDRESS OF FACILITY: Fellows-Wells Funeral Home 413 High St., Chestertown, MD 21620	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	ASCVD with Ventricular Fibrillation.	10-20yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Aortic regurgitation	10-20yrs
DUE TO (OR AS A CONSEQUENCE OF): c.	COPD.	10-20yrs.
DUE TO (OR AS A CONSEQUENCE OF): d.	(all information from Dr Fauntleroy)	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: NA

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [/] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [/] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [/] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [/] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [/] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dr Cornelius Stamp, MD.	29c. LICENSE NUMBER: D 38107	29d. DATE SIGNED (Month, Day, Year) ▶ 3-7-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr Cornelius Stamp Kent + Queen Anne's Hospital Chestertown, MD. 21620

31. DATE FILED (Month, Day, Year): MAR 9 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09317

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lillian Haynes		2. DATE OF DEATH (Month, Day, Year): 2 26 92	3. TIME OF DEATH: 10:00 pM
4. SOCIAL SECURITY NUMBER: 578-86-8611	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 3 1913
8. BIRTHPLACE (State or Foreign Country): Mich.			
9a. FACILITY NAME (If not institution, give street and number): Harrison Home	9b. CITY, TOWN OR LOCATION OF DEATH: Snow Hill MD	9c. COUNTY OF DEATH: Worcester	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Worchseter	10c. CITY, TOWN OR LOCATION: Snow Hill	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 430 Market St.	10f. ZIP CODE: 21863	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker	16b. KIND OF BUSINESS/INDUSTRY: n/a	
17. FATHER'S NAME (First, Middle, Last): Thomas Schaller	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel Mooney Schaller		
19a. INFORMANT'S NAME (Type/Print): Kathleen Dianne Dillehay	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 600 Old Bucklodge Ln. Boyds, MD 20841		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olive Cemetery	20c. LOCATION — City or Town, State: Felton, Delaware	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph Fleegle	22. NAME AND ADDRESS OF FACILITY: Fleegle-Heffenbein Fly. PoBox 160 Greensboro Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. A(T)D	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. FHD (? uncertain)	
	DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes	
	DUE TO (OR AS A CONSEQUENCE OF): d. Senile Dementia	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: E Gwell MD	29c. LICENSE NUMBER: D15081	29d. DATE SIGNED (Month, Day, Year): 2-27-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E Gwell MD Harrison Home Snow Hill MD		
31. DATE FILED (Month, Day, Year): MAR 3 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

92 09318

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
RAYMOND	Heston	HEWITT	March 19, 1992	10:05 PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
214-05-4691	1 [X] M 2 [ ] F	97 YRS.			Jan 5, 1895	Md.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Memorial Hospital	Cumberland	Allegany

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Md.	Allegany	Cumberland	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
509 Franklin St.	21502	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO — WW1	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Sales Agent	Insurance

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
William H. Hewitt	Clara Brant

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Thelma Hewitt	509 Franklin St. Cumberland, Md. 21502

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Hillcrest Burial Park	Mar 23,92	Cumberland, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Robert C. Adams	Merritt-Adams Funeral Home 404 Decatur St. Cumberland, Md. 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe dehydration
Gangrene Right foot

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D 33280	▶ 3/20/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. S. Gupta, Johnson Heights Medical Bldg., Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 23 1992	[signature]

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7

92 09319

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alberta Olivia Johnson					2. DATE OF DEATH (Month / Day / Year): 3 / 4 / 92	3. TIME OF DEATH: 4:21 P M
4. SOCIAL SECURITY NUMBER: 221-20-7587	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Mar 24, 1905	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): The Kent and Queen Annes Hospital, Inc.			9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown		9c. COUNTY OF DEATH: Kent	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Kent	10c. CITY, TOWN OR LOCATION: Millington	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: RD #1, Box 316		10f. ZIP CODE: 21651	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Walter Hackett		18. MOTHER'S NAME (First, Middle, Maiden Surname): Della Adams	
19a. INFORMANT'S NAME (Type/Print): Jeanette Johnson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 569, Chestertown, MD 21620	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Asbury Cemetery DATE: 3/9/92	20c. LOCATION — City or Town, State: Chesterville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary B. Fellows		22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home, P.A. 21651 370 W. Cypress St., Millington, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hypertrophic Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kin K. Wien, MD.	29c. LICENSE NUMBER: D21313	29d. DATE SIGNED (Month, Day, Year) ▶ 3/4/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KIN K. WIEN, 216 High St, Chestertown, Md. 21620		
31. DATE FILED (Month, Day, Year): MAR 9 '92	32. REGISTRAR'S SIGNATURE: Jeanne Davison-Hampshire	

4

DHMH-16 Rev 1/89

3

92 09320

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alpha Janney / ALPHA (NMN) JANNEY			2. DATE OF DEATH (Month, Day, Year): 3-10-1992	3. TIME OF DEATH: 12:20 AM
4. SOCIAL SECURITY NUMBER: 220-22-3415	5. SEX: 1 ☐ M 2 ☒ F	8. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 14, 1906	8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace	9c. COUNTY OF DEATH: Harford	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Joppa	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1618 Dugan Dr.		10f. ZIP CODE: 21085	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Welder	16b. KIND OF BUSINESS/INDUSTRY: Electronics	
17. FATHER'S NAME (First, Middle, Last): Albert --- Elkins	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lou --- Maggard		
19a. INFORMANT'S NAME (Type/Print): Betty J. Janney	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1618 Dugan Dr., Joppa, Md. 21085		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bel Air Memorial Gardens DATE: 3-12-92	20c. LOCATION — City or Town, State: Bel Air, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III	22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF):	5 YRS.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Severe Peripheral Valvular disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: KMithani MD	29c. LICENSE NUMBER: D 32609	29d. DATE SIGNED (Month, Day, Year): ▶ 3/10/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KAMRUDIN MITHANI MD. 703 REVOLUTION ST. HAVRE DE GRACE MD 21078

31. DATE FILED (Month, Day, Year): MAR 11 92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09321

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ARTHUR WYMAN JOHNSON
2. DATE OF DEATH (Month, Day, Year): February 24 1992
3. TIME OF DEATH: 3:12PM M
4. SOCIAL SECURITY NUMBER: 363-22-4576
5. SEX: 1 [X] M 2 [ ] F
6. AGE (If yrs. last birthday): 68 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 09/06/23
8. BIRTHPLACE (State or Foreign Country): Missouri
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital at Easton
9b. CITY, TOWN OR LOCATION OF DEATH: Easton
9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Caroline
10c. CITY, TOWN OR LOCATION: Greensboro
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: Rt. 1, Box 21, Main St.
10f. ZIP CODE: 21639
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plant Manager
16b. KIND OF BUSINESS/INDUSTRY: Marine
17. FATHER'S NAME (First, Middle, Last): James Johnson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Throope Johnson
19a. INFORMANT'S NAME (Type/Print): Agnes Johnson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 21, Main St., Greensboro, MD 21639
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Greensboro Cemetery — DATE: 2/27/92
20c. LOCATION — City or Town, State: Greensboro, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Fleegle-Helfenbein Funeral Home, 106 Sunset Ave., Greensboro, MD 21639

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Ventricular Fibrillation	30 mins
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Ischaemic Cardiomyopathy	6 years
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Coronary Artery Disease -	10 years
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MC Rajasingh M.D.
29c. LICENSE NUMBER: D41723
29d. DATE SIGNED (Month, Day, Year): 2/24/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. Christadoss RAJASINGH, 403, Marvel Court, Easton, MD. 21601
31. DATE FILED (Month, Day, Year): MAR 3 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09322
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Dennis Jones				2. DATE OF DEATH (Month, Day, Year): March 14, 1992	3. TIME OF DEATH: 6:00 P M
4. SOCIAL SECURITY NUMBER: 219-14-3592	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)		7. DATE OF BIRTH (Month, Day, Year): 10 02 1926	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Hobbs Road Rt. 1 Box 106		9b. CITY, TOWN OR LOCATION OF DEATH: Denton		9c. COUNTY OF DEATH: Caroline	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Denton	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Hobbs Road Rt. 1 Box 106		10f. ZIP CODE: 21629	10g. CITIZEN OF WNAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR OATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEOENT'S EOUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th gr. / College (1-4 or 5+): None	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plumbing & Heating	16b. KINO OF BUSINESS/INDUSTRY: Plumbing & Heating	
17. FATHER'S NAME (First, Middle, Last): W. Scott Jones		18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Dennis	
19a. INFORMANT'S NAME (Type/Print): Ethel M. Jones		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1 Box 106, Denton, MD 21629	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND OATE OF DISPOSITION (Name of cemetery, crematory or other place): Greenlawn Cemetery / OATE: 3/17	20c. LOCATION — City or Town, State: Cambridge, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph P. Moore		22. NAME AND ADDRESS OF FACILITY: Moore Funeral Home, P.A. Drawer B, Denton, Maryland 21629	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 6/24/92

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colon Cancer, metastatic

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETIDN DF CAUSE DF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF OEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D39887	29d. DATE SIGNED (Month, Day, Year): ▶ 3/18/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. OATE FILED (Month, Day, Year): MAR 19 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

92 09323

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Audrey G. Johnson					2. DATE OF DEATH (Month, Day, Year): 03 22 92		3. TIME OF DEATH: 1400 M
4. SOCIAL SECURITY NUMBER: 233-36-0752	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 25, 1914		8. BIRTHPLACE (State or Foreign Country): West Virginis
9a. FACILITY NAME (If not institution, give street and number): Union Hospital of Cecil County			9b. CITY, TOWN OR LOCATION OF DEATH: Elkton				9c. COUNTY OF DEATH: Cecil
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Cecil		10c. CITY, TOWN OR LOCATION: Elkton				10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 228 Whitehall Road			10f. ZIP CODE: 21921				10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11	College (1-4 or 5+):		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY:		
17. FATHER'S NAME (First, Middle, Last): Dee Lusk			18. MOTHER'S NAME (First, Middle, Maiden Surname): Ada Bailey				
19a. INFORMANT'S NAME (Type/Print): Paul J. Johnson			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 228 Whitehall Road - Elkton, MD 21921				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bethel Cemetery	DATE: 3-25 1992	20c. LOCATION — City or Town, State: Chesapeake City, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ralph E Hicks			22. NAME AND ADDRESS OF FACILITY: Hicks Home for Funerals, PA 103 West Stockton Street Elkton, MD 21921-5521				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ehock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final diseese or condition resulting in death) →	a. Respiratory Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Metastatic Transitional Cell Bladder Ca	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. H/O Non-Hematogenous MI	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Timothy O'Donnell MD ATTENDING	D 33510	▶ 3/24/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Timothy O'Donnell Suite 32 Peoples Plaza Glasgow, De

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 24 '92	Celia Davidson-Randall

DHMH-16 Rev 1/89

3

92 09324

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SARAH E. JOHNSTON				2. DATE OF DEATH (Month, Day, Year): March 18, 1992	3. TIME OF DEATH: 9:20 AM
4. SOCIAL SECURITY NUMBER: 233-44-5374	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 14 1927	8. BIRTHPLACE (State or Foreign Country): WV.
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany
RESIDENCE OF DECEDENT					
10a. STATE: WV	10b. COUNTY: Mineral	10c. CITY, TOWN OR LOCATION: Piedmont			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 84 W. Harrison St.			10f. ZIP CODE: 26750		10g. CITIZEN OF WHAT COUNTRY? US
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Simom Farris			18. MOTHER'S NAME (First, Middle, Maiden Surname): Vera Dixon		
19a. INFORMANT'S NAME (Type/Print): John J. Johnson Sr.			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 84 W. Harrison St. Piedmont, WV. 26750		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Philos Cemetery DATE: 3-21-92		20c. LOCATION — City or Town, State: Westernport, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frederick W Warnick			22. NAME AND ADDRESS OF FACILITY: Boal-Warnick Funeral Service 111 Church St. Westernport, Md. 21562		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or reepiratory erreet, shock, or heert feilure. List only one cause on each line.

		Approximate Interval Between Oneat and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Myocardial Infarction	24 Hrs
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Right leg arterial Ischemia c ulcers	4-6 weeks
	c. DUE TO (OR AS A CONSEQUENCE OF): Diabetes mellitus	—
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. —

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETIDN OF CAUSE DF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner aa stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner aa stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Phil J Schroeder MD	D 17456	▶ 3/20/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. P. Schroeder, Memorial Hospital, 600 Memorial Avenue, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 23 1992	Joan Davidson-Randall

DHMH-16 Rev 1/89

10

92 09325

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ARTHUR Donald JONES			2. DATE OF DEATH (Month, Day, Year): March 23 1992	3. TIME OF DEATH: 4:30 a.m.
4. SOCIAL SECURITY NUMBER: 219-32-2858	5. SEX: X 1 M 2 F	6. AGE (In yrs. last birthday): 96 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/3/1895	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 610 Oak St.		9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge		9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Cambridge	10d. INSIDE CITY LIMITS? 1 ☐ YES X NO
10e. STREET AND NUMBER: 610 Oak St.		10f. ZIP CODE: 21613	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW I	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farm Equipment Dealer	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): James Radcliffe Jones		18. MOTHER'S NAME (First, Middle, Maiden Surname): Miriam Navy	
19a. INFORMANT'S NAME (Type/Print): Donald K. Jones		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1550 Paw Paw Pt. Cambridge, Md 21613	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Jones Family Cemetery	20c. LOCATION — City or Town, State: Cambridge MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kenneth R Thomas J		22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge Md. 21613	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PROSTATIC CARCINOMA	2 YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY — M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael A. Moskowicz MD	29c. LICENSE NUMBER: D-16609	29d. DATE SIGNED (Month, Day, Year): ▶ 3/23/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL A. MOSKOWICZ MD 503 BYRN ST CAMBRIDGE MD 21613

31. DATE FILED (Month, Day, Year): MAR 24 '92	32. REGISTRAR'S SIGNATURE: [illegible] Davidson-Randall

DHMH-16 Rev 1/89

92 09326

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Elizabeth Kulley			2. DATE OF DEATH (Month, Day, Year): 3-12-1992	3. TIME OF DEATH: 1:25Am M
4. SOCIAL SECURITY NUMBER: 149 05 8665	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-26-1909	8. BIRTHPLACE (State or Foreign Country): MAryland
9a. FACILITY NAME (If not institution, give street and number): Kent & Queen Anne's County Hospital INC.	9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown		9c. COUNTY OF DEATH: Kent	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Kent	10c. CITY, TOWN OR LOCATION: Chestertown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: RFD Morgnec		10f. ZIP CODE: 21620	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced — Never Mar.	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES: No	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: No	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY: Insurance Co	
17. FATHER'S NAME (First, Middle, Last): Walter Edward Kulley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Essie McGinnis	
19a. INFORMANT'S NAME (Type/Print): The Deceased while living		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Chestertown, RFD Morgnec 21620	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Burial	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sudlersville Cemetery (3/16/92)	DATE	20c. LOCATION — City or Town, State: Sudlersville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. Willis Wells	22. NAME AND ADDRESS OF FACILITY: Fellows - Wells	413 High St. Chestertown, Md. 21620	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia Exacerbating COPD	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ca ⓑ Breast with Bone & Liver Metastases

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible], MD	29c. LICENSE NUMBER: D 21313	29d. DATE SIGNED (Month, Day, Year): 3/13/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kim K. Winn, 216 High St, Chestertown, Md. 21620		
31. DATE FILED (Month, Day, Year): MAR 16 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

92 09327

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Martha Elizabeth KINNAMON			2. DATE OF DEATH (Month, Day, Year): Feb. 24 1992	3. TIME OF DEATH: 1015 M
4. SOCIAL SECURITY NUMBER: 213-22-6279	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/18/26	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY		9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Wicomico	10c. CITY, TOWN OR LOCATION: Salisbury	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 514 Emory Ct.		10f. ZIP CODE: 21801	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Domestic	
17. FATHER'S NAME (First, Middle, Last): Lemuel C. Kinnamon		18. MOTHER'S NAME (First, Middle, Maiden Surname): Christine Palmatary Kinnamon	
19a. INFORMANT'S NAME (Type/Print): James C. Kinnamon		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 514 Emory Ct., Salisbury, MD 21801	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Greensboro Cemetery	DATE: 2/27/92	20c. LOCATION — City or Town, State: Greensboro, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Myrle C Fleegle		22. NAME AND ADDRESS OF FACILITY: Fleegle-Helfenbein Funeral Home 106 Sunset Ave., Greensboro, MD 21639	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Inferior Wall Myocardial Infarct	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):	
	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End-Stage Renal Disease. 2° to Diabetes Mellitus
Long Standing Diabetes
Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURRED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Benito S. Chan MD	29c. LICENSE NUMBER: D-20050	29d. DATE SIGNED (Month, Day, Year) ▶ 2/24/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BENITO S. CHAN 547-D Riverside Dr. Salisbury MD 21801

31. DATE FILED (Month, Day, Year): MAR 3 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rhodes

DHMN-16 Rev 1/89

92 09328

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNA T. KOWALEWSKI
2. DATE OF DEATH — MONTH: 3 DAY: 15 YEAR: 92
3. TIME OF DEATH: 11:40 A M
4. SOCIAL SECURITY NUMBER: 218-03-9956
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-20-1913
8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY M.C.
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 904 S. CURLEY ST.
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): ✓ — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): JOSEPH MALKOWSKI
18. MOTHER'S NAME (First, Middle, Maiden Surname): GERTRUDE GOLEMBIESKI
19a. INFORMANT'S NAME (Type/Print): RAYMOND KOWALEWSKI
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2914 DILLON ST. BALTO., MD. 21224
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): ST. STANISLAUS CEM — DATE: 3-18-92
20c. LOCATION — City or Town, State: BALTO. CO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas J. Skalda Jr.
22. NAME AND ADDRESS OF FACILITY: SKALDA F.H. 2829 HUDSON ST. 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS	days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. perforated bowel DUE TO (OR AS A CONSEQUENCE OF):	weeks
	c. diverticular stricture sigmoid colon DUE TO (OR AS A CONSEQUENCE OF):	weeks
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: end stage renal disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) — 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: H. STRAUS MD house staff FSK/Hopkins
29c. LICENSE NUMBER: AJ4147357
29d. DATE SIGNED (Month, Day, Year): ▶ 3/15/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HELEN STRAUS Francis Scott Key Hospital
31. DATE FILED (Month, Day, Year): MAR 18 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

12

92 09329

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Arthur Abraham Kruger					2. DATE OF DEATH (Month, Day, Year): MARCH 10 1992		3. TIME OF DEATH: 2 24 AM
4. SOCIAL SECURITY NUMBER: 129 - 05 - 4107	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 6, 1911		8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Beltsville Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Laurel			9c. COUNTY OF DEATH: Prince George	
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Prince George		10c. CITY, TOWN OR LOCATION: Laurel			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 14742 4th Street			10f. ZIP CODE: 20707			10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Costumer			16b. KIND OF BUSINESS/INDUSTRY: West Costumers	
17. FATHER'S NAME (First, Middle, Last): Isaac Kruger			18. MOTHER'S NAME (First, Middle, Maiden Surname): Katie Fishman				
19a. INFORMANT'S NAME (Type/Print): Eva S. Kruger			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14742 4th Street, Laurel, Maryland 20707				
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.			20c. LOCATION — City or Town, State: Catonsville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ DeWitt Jay Donaldson Sr.			22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac arrhythmia	hours
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. coronary artery disease	years
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D0664A	▶ March 10, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 8383 CHERRY LN LAUREL MD 20707

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 12 '92	Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09330

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARLIN JOHN KING
2. DATE OF DEATH (Month, Day, Year): 03 19 92
3. TIME OF DEATH: 02:32 AM
4. SOCIAL SECURITY NUMBER: 201 01 7610
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 76 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 05-31-15
8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: LaVale,
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO XX
10e. STREET AND NUMBER: Route 1 Box 70-B
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 XX Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 XX NO — IF YES, GIVE WAR OR OATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 XX NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): minister
16b. KIND OF BUSINESS/INDUSTRY: First Church of God
17. FATHER'S NAME (First, Middle, Last): Boyd King
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Keith
19a. INFORMANT'S NAME (Type/Print): Mrs. Susan Marie King
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 1 Box 70B LaVale, MD 21502
20a. METHOD OF DISPOSITION: 1 X Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Sunset Memorial Park — DATE: 3/21
20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James J Scarpelli
22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	METASTATIC PROSTATE CARCINOMA	1YR
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
VENTRICULAR ARRHYTHMIA
PNEUMONIA

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 X NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 X NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 X Inpatient 2 [ ] ER/Outpatient 3 [ ] OOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Paul S. Livengood MD
29c. LICENSE NUMBER: D23774
29d. DATE SIGNED (Month, Day, Year): 3-19-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. PAUL LIVENGOOD, M.D., 912 SETON DRIVE, CUMBERLAND, MD 21502
31. DATE FILED (Month, Day, Year): MAR 20 1992
32. REGISTRAR'S SIGNATURE: Joan Lawson-Kendall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

92 09331

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Earl Reynolds Lane, Sr.					2. DATE OF DEATH (Month, Day, Year): 3 / 1 / 92	3. TIME OF DEATH: 12:25 PM
4. SOCIAL SECURITY NUMBER: 214-12-5251	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 08 16 1917	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Wesleyan Health Care Center			9b. CITY, TOWN OR LOCATION OF DEATH: Denton			9c. COUNTY OF DEATH: Caroline
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Queen Anne		10c. CITY, TOWN OR LOCATION: Grasonville			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Saw Mill Lane			10f. ZIP CODE: 21638			10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown / College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer			16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Carol Rane			18. MOTHER'S NAME (First, Middle, Maiden Surname): Amy Dennis			
19a. INFORMANT'S NAME (Type/Print): Victoria Lane			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 302, Denton, Maryland 21629			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cem. MD Eastern Shore Vet.		DATE: 3/6	20c. LOCATION — City or Town, State: Beulah, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randolph P. Moore			22. NAME AND ADDRESS OF FACILITY: MOORE F.H., P.A. 12 S 2nd St. DRAWER B. Denton, Md 21629			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Prostate Cancer

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
James Sides MD	D31376	3-4-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Sides PO Box 496 Denton Md 21629

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 6 '92	Julia Davidson-Randall

OHMH-16 Rev 1/89

92 09332

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SUE EVELYN LEWIS				2. DATE OF DEATH (Month, Day, Year): March 21 1992	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-16-7376	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec.31,1900	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 2625 Hoopers Island Rd.			9b. CITY, TOWN OR LOCATION OF DEATH: Fishing Creek		9c. COUNTY OF DEATH: DORCHESTER
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Fishing Creek			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2625 Hoopers Island Rd.			10f. ZIP CODE: 21634		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Crab Picker	16b. KIND OF BUSINESS/INDUSTRY: Shellfish			
17. FATHER'S NAME (First, Middle, Last): Samuel H. Tolley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Rebecca Parker			
19a. INFORMANT'S NAME (Type/Print): Mrs. Lola Ruark	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2625 Hoopers Island Rd. Fishing Creek,Md. 21634				
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dorchester Mem'l. Cem.	20c. LOCATION — City or Town, State: Cambridge, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond Curran	22. NAME AND ADDRESS OF FACILITY: MO0125 Curran Funeral Home 308 High St. Cambridge,Md.				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebrovascular accident
DUE TO (OR AS A CONSEQUENCE OF):
b. Multi-infarct Dementia
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic Atrial Fibrillation
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Judy C. Washington	D31108	▶ 3/23/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Judy C. Washington, 408 Byrn Street Cambridge

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 24 '92	Gloria Davidson-Randall

DHMH-16 Rev 1/89

92 09333

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be detached for use as the burial-transit permit if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DORA E. MOORE			2. DATE OF DEATH (Month / Day / Year): 03 / 22 / 92	3. TIME OF DEATH: 6:55 AM M
4. SOCIAL SECURITY NUMBER: 229-05-5911	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-18-14	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): DEER'S HEAD CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY		9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: Virginia	10b. COUNTY: Accomack	10c. CITY, TOWN OR LOCATION: Saxis	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: N/A	10f. ZIP CODE: 23427	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Domestic	
17. FATHER'S NAME (First, Middle, Last): Ross D. Linton		18. MOTHER'S NAME (First, Middle, Maiden Surname): Olive Sterling	
19a. INFORMANT'S NAME (Type/Print): Charles Moore		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Saxis, VA 23427	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baptist Cemetery	20c. LOCATION — City or Town, State: Saxis, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Carl A. Thornton		22. NAME AND ADDRESS OF FACILITY: Thornton Funeral Home, Chadbourne St., Parksley, VA 23421	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. METASTIC CANCER TO THE LUNG
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CARCINOMA OF THE RIGHT PAROTID GLAND
DUE TO (OR AS A CONSEQUENCE OF):
c. RIGHT HIP FRACTURE
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Benito S. Chan MD	29c. LICENSE NUMBER: D- 20050	29d. DATE SIGNED (Month, Day, Year): 03-22-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. BENITO S. CHAN 547-D RIVERSIDE DR. SALISBURY, MARYLAND 21801

31. DATE FILED (Month, Day, Year): MAR 31 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92-09334

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY ELIZABETH MARTIN
2. DATE OF DEATH (Month, Day, Year): 03-13-1992
3. TIME OF DEATH: 1:35 A. M
4. SOCIAL SECURITY NUMBER: 214-07-3400
5. SEX: 1 ☐ M 2 XX F
6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 08-31-1909
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): MORAN MANOR NURSING HOME
9b. CITY, TOWN OR LOCATION OF DEATH: WESTERNPORT
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Cumberland,
10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 638 Columbia Avenue
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): former employee
16b. KIND OF BUSINESS/INDUSTRY: C & P Telephone Co.
17. FATHER'S NAME (First, Middle, Last): John L. Becker, SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen T. Cain
19a. INFORMANT'S NAME (Type/Print): Mr. DAvid Martin, Sr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1540C Oldtown Manor Apt. Cumberland, MD 21502
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Restlawn Memorial Gardens — DATE: 3-16
20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli
22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arterio Sclerotic Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Acute myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
c. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 XX NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 XX NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 XX Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James H Zo
29c. LICENSE NUMBER: D21244
29d. DATE SIGNED (Month, Day, Year): 3/18/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. JESUS TAN, M.D., FROSTBURG PLAZA, FROSTBURG, MD 21532

31. DATE FILED (Month, Day, Year): MAR 23 1992
32. REGISTRAR'S SIGNATURE: Jessica Davidson-Randall

5

DHMH-16 Rev 1/89

92 09335

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James A. McConnell

2. DATE OF DEATH Month: 03 Day: 20 Year: 92

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 216 36 1855

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 50 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 07 03 41

8. BIRTHPLACE (State or Foreign Country): Pennsylvania

9a. FACILITY NAME (If not institution, give street and number): HowCo General Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Columbia, Md

9c. COUNTY OF DEATH: Howard Carroll

RESIDENCE OF DECEDENT

10a. STATE: Md

10b. COUNTY: Carroll

10c. CITY, TOWN OR LOCATION: Sykesville.

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 6908 Sheffield Drive

10f. ZIP CODE: 21784

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 5+

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor

16b. KIND OF BUSINESS/INDUSTRY: Materials Control Baltimore Gas & Electric

17. FATHER'S NAME (First, Middle, Last): Arthur J. McConnell

18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice C. Jordan

19a. INFORMANT'S NAME (Type/Print): Mrs. Mary McConnell

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6908 Sheffield Drive Sykesville, MD 21784

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park
DATE: 3/24

20c. LOCATION — City or Town, State: Glen Burnie, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian L. Haight

22. NAME AND ADDRESS OF FACILITY: Haight Funeral Home (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Myocardial Infarction
OUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Coronary Artery Disease
OUE TO (OR AS A CONSEQUENCE OF):
c. Hypertension
OUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Terri Gershon MD

29c. LICENSE NUMBER: D26669

29d. DATE SIGNED (Month, Day, Year): ▶ 3-20-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Terri Gershon MD Howard County General Hospital

31. DATE FILED (Month, Day, Year): MAR 23 '92

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMH-16 Rev 1/89

92-57

92-1660-510

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92-09336

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Autry FOYE , Jr.			2. DATE OF DEATH (Month, Day, Year): 03 20 1992	3. TIME OF DEATH: 9:27 PM
4. SOCIAL SECURITY NUMBER: 096-56-8017	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 21 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1-22-1971	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): University Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: New York	10b. COUNTY: New York	10c. CITY, TOWN OR LOCATION: New York		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 675 Water Street		10f. ZIP CODE: 10002		10g. CITIZEN OF WHAT COUNTRY? U. S. A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer		16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Autry Foye,Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Beverly Johnson		
19a. INFORMANT'S NAME (Type/Print): Autry Foye,Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 675 Water Street New York, New York 10002		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rosemount Cemetery	DATE: 3/28	20c. LOCATION — City or Town, State: Newark,New Jersey
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael P. Marzullo		22. NAME AND ADDRESS OF FACILITY: Marzullo Funeral Service 3981 Carrollton Road Upperco,MD. 21155		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → e. Multiple Gunshot Wounds

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 03 20 1992	28b. TIME OF INJURY: 8:45 PM	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Subject shot
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): on street			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 700 blk. N. Mount Street

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ 03 21 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK J. PETTI MD	111 Penn Street, Baltimore Maryland 21201	
31. DATE FILED (Month, Day, Year): MAR 27 '92	32. REGISTRAR'S SIGNATURE: [illegible]	

DHMH-18 Rev 1/89

92 09337

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evelyn MacDonald			2. DATE OF DEATH (Month, Day, Year): March 15, 1992	3. TIME OF DEATH: 3:30 A M
4. SOCIAL SECURITY NUMBER: 215-16-8703	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 11 11 1900	8. BIRTHPLACE (State or Foreign Country): Delaware
9a. FACILITY NAME (If not institution, give street and number): Liden School Road, Rt.2 Box 174		9b. CITY, TOWN OR LOCATION OF DEATH: Federalsburg		9c. COUNTY OF DEATH: Caroline
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Federalsburg		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Liden School Road, Rt.2 Box 174		10f. ZIP CODE: 21632		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 HS grad; College (1-4 or 5+): None		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATNER'S NAME (First, Middle, Last): John Robert Torbert		18. MOTNER'S NAME (First, Middle, Maiden Surname): Sarah Elizabeth Adams		
19a. INFORMANT'S NAME (Type/Print): Evelyn M. Collins		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 3 Box 241-H, Harrington, DE 19952		
20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Denton Cemetery	DATE: 3/18	20c. LOCATION — City or Town, State: Denton, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph Moore		22. NAME AND ADDRESS OF FACILITY: Moore Funeral Home, P.A. Drawer B, Denton, Maryland 21629		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. diabetes

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: hypertension, severe osteo-arthritis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D33768	29d. DATE SIGNED (Month, Day, Year) ▶ 3/16/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. CORWIN M.D. P.O. BOX 660 DENTON MD 21629		
31. DATE FILED (Month, Day, Year): MAR 18 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMH-18 Rev 1/89

92 09338

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leonard W. Miles
2. DATE OF DEATH: MONTH 3 DAY 22 YEAR 92
3. TIME OF DEATH: 11 18 PM
4. SOCIAL SECURITY NUMBER: 212-10-8270
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 1/29/12
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Carroll Co Gen. Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Westminster
9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Carroll
10c. CITY, TOWN OR LOCATION: Millers
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4705 Alesia Lineboro Rd.
10f. ZIP CODE: 21107
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Glass Cutter
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Albert Miles
18. MOTHER'S NAME (First, Middle, Maiden Surname): Nora Hoffman
19a. INFORMANT'S NAME (Type/Print): Evelyn Miles
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4705 Alesia Lineboro Rd., Millers, Md. 21107
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): New Lutheran Cem. DATE: 03/25/92
20c. LOCATION — City or Town, State: Manchester, Md. 21102
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: H.J. Eckhardt
22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel Manchester, Md. 21102

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinomatosis — 1 yr

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Carcinoma Colon — 1 yr.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John E. Steers M.D.
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 3/23/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John E. STEERS M.D. Suite 102 Billingslea Bldg, Westminster Md. 21157
31. DATE FILED (Month, Day, Year): MAR 24 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 5 and 6 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09339

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BRUCE ARNOLD MYERS			2. DATE OF DEATH (Month, Day, Year): 3-15-92	3. TIME OF DEATH: 18:55 M
4. SOCIAL SECURITY NUMBER: 220-16-6490	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-16-23	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND		9c. COUNTY OF DEATH: ALLEGANY
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Garrett	10c. CITY, TOWN OR LOCATION: Frostburg		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Star Route, Box 9		10f. ZIP CODE: 21532		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: W.W. 2	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction		16b. KIND OF BUSINESS/INDUSTRY: Local Union
17. FATHER'S NAME (First, Middle, Last): Orville M. Myers		18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Chisholm		
19a. INFORMANT'S NAME (Type/Print): Pansy Myers		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Star Route, Box 9, Frostburg, Md. 21532		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Johnson Cemetery	DATE: 3/18	20c. LOCATION — City or Town, State: Garrett Co., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Hess		22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Acute ~~Pneumonia~~ Pneumonitis

DUE TO (OR AS A CONSEQUENCE OF):

c. Generalized Cachexia

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of Bladder with metastasis

Chronic Obstructive Lung disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D21244	29d. DATE SIGNED (Month, Day, Year): ▶ 3/16/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. JESUS TAN, M.D., FROSTBURG PLAZA, FROSTBURG, MD 21532

31. DATE FILED (Month, Day, Year): MAR 18 1992	32. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall

DHMH-16 Rev 1/89

92 09340

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)		3. TIME OF DEATH
BESSIE R Bessie Webster MEREDITH			3 - 22 - 92		4:01 PM
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
217-10-8913	1 ☐ M ☒ F	74 YRS.			8/18/1917	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Dorchester General Hospital	Cambridge	Dorchester

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Dorchester	Cambridge	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2073 Dailsville Road	21613	US

11. MARITAL STATUS 1 ☐ Never Married ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
11	Garment Worker/Cook	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
John Webster	Lena Ewell

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John C. Meredith	2073 Dailsville Rd Cambridge, Md. 21613

20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place)	DATE	20c. LOCATION — City or Town, State
	Antioch Churchyard	3/25	Cambridge, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ John W. Thomas	22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St Cambridge, Md. 21613

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CEREBRAL HYPOXIA	24 hours
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. HYPO TENSION	"
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. MYOCARDIAL INFARCTION	"
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. ATHEROSCLEROSIS	YEARS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH 1 ☒ Natural 5 ☐ Pending Investigation 2 ☐ Accident 3 ☐ Suicide 8 ☐ Could not be determined 4 ☐ Homicide	28a. DATE OF INJURY (Month, Day, Year) —	28b. TIME OF INJURY — M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED —
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) —		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) —		

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Michael A. Moskowitz MD	29c. LICENSE NUMBER D-16609	29d. DATE SIGNED (Month, Day, Year) ▶ 3-22-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Michael A. Moskowitz MD 503 BYRN ST. CAMBRIDGE MD. 21613

31. DATE FILED (Month, Day, Year) MAR 24 92	32. REGISTRAR'S SIGNATURE Davidson-Randall

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

92 09341

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): AMY C. KERNS NOLAND

2. DATE OF DEATH MONTH: 3 DAY: 16 YEAR: 92

3. TIME OF DEATH: 3:00PM M

4. SOCIAL SECURITY NUMBER: 236 68 4825

5. SEX: 1 ☐ M 2 ☒ F

8. AGE (In yrs. last birthday): 88 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 6-13-03

6. BIRTHPLACE (State or Foreign Country): Short Gap WV

9a. FACILITY NAME (If not institution, give street and number): Cumberland Nursing Home

9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland

9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: Allegany

10c. CITY, TOWN OR LOCATION: Cumberland,

10d. INSIDE CITY LIMITS? XX 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: Old Towne Manor Apts.

10f. ZIP CODE: 21502

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed XX 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO XX Specify:

14. RACE — American Indian, Black, White, etc.
Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker

16b. KIND OF BUSINESS/INDUSTRY: own home

17. FATHER'S NAME (First, Middle, Last): John W. Whitacre

18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Amanda Herrick

19a. INFORMANT'S NAME (Type/Print): Mrs. M. Louise Brelsford

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Short Gap, WV

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park 3-19

20c. LOCATION — City or Town, State: Cumberland, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James J. Scarpelli

22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute respiratory failure	2 days
DUE TO (OR AS A CONSEQUENCE OF): b.	Probable Aspiration	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Carcinoma of Breast
Coronary artery disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: D33280

29d. DATE SIGNED (Month, Day, Year): ▶ 3/18/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. S. Gupta, M.D.; JHMB Suite 101, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): MAR 18 1992

32. REGISTRAR'S SIGNATURE

3

OHMH-16 Rev 1/89

92 09342

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Justino Lindy Paniere			2. DATE OF DEATH (Month, Day, Year): 3-5- 1992	3. TIME OF DEATH: 6:35Am M
4. SOCIAL SECURITY NUMBER: 217-52-1085	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 42 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept 3,1949	8. BIRTHPLACE (State or Foreign Country): DE
9a. FACILITY NAME (If not institution, give street and number): Kent & Queen Anne's Co. Hospital INC.		9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown	9c. COUNTY OF DEATH: Kent	

RESIDENCE OF DECEDENT

10a. STATE: VA	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Hopewell	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3604A Portsmouth Street		10f. ZIP CODE: 23860	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Senior Associate Editor	16b. KIND OF BUSINESS/INDUSTRY: Army Logistician Magazine

17. FATHER'S NAME (First, Middle, Last): John Paniere	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Mae Darling
19a. INFORMANT'S NAME (Type/Print): Annabelle Taylor	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt 1, Box 40B, Marydel,MD 21648

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sudlersville Cemetery	DATE: 3/9/92	20c. LOCATION — City or Town, State: Sudlersville,MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary B Fellows		22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home,P.A. 21651 370 W. Cypress St.,Millington,MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] ND

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] ND
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D-13824	29d. DATE SIGNED (Month, Day, Year): ▶ 3-5-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Medical Bldg., Chestertown, MD 21620

31. DATE FILED (Month, Day, Year): MAR 4 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09343

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 through 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Henry T. PRICE Jr.						2. DATE OF DEATH (Month, Day, Year): March 17, 1992	3. TIME OF DEATH: 6:29PM M
4. SOCIAL SECURITY NUMBER: 215 32 5954	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		7. DATE OF BIRTH (Month, Day, Year): 09-20-1935	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital Center			9b. CITY, TOWN OR LOCATION OF DEATH: Rossville			9c. COUNTY OF DEATH: Baltimore County	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Havre de Grace	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 604 N. Adams Street		10f. ZIP CODE: 21078	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): (Ret) Service Manager	16b. KIND OF BUSINESS/INDUSTRY: Distributing Company	
17. FATHER'S NAME (First, Middle, Last): Henry Tilliman Price, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Hasson	
19a. INFORMANT'S NAME (Type/Print): Mrs. Alma Neff Price		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 604 N. Adams Street, Havre de Grace, MD 21078	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Angel Hill Cemetery	DATE: 3/21	20c. LOCATION — City or Town, State: Havre de Grace, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William S. Smith II		22. NAME AND ADDRESS OF FACILITY: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Ruptured aortic aneurism
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
d. COPD

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? X 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: P36715	29d. DATE SIGNED (Month, Day, Year): ▶ 3-18-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Ossman 504 Lewis Street, Havre De Grace, Md.		
31. DATE FILED (Month, Day, Year): MAR 20 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

92-1378-025

92 09344

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH Month / Day / Year	3. TIME OF DEATH
KEVIN	JEFFREY	POZNANIAK	03 / 09 / 1992	11:52 P.M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
215-15-0076	1 [X] M 2 [ ] F	15 YRS.			Dec. 1, 1976	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
HARFORD MEMORIAL HOSPITAL	HAVRE DE GRACE	HARFORD

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Harford	Edgewood	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
308 Palmetto Drive	21040	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5 +)		
10		Student	High School

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Kenneth Joseph Poznaniak	Theresa Anne Lewis

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kenneth J. Poznaniak	308 Palmetto Drive, Edgewood, Md. 21040

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
[X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Mt. Zion Cemetery	3-13-92	Bel Air, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Howard K McComas III	Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple Injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	03-09-1992	6:30PM.	1 [ ] YES 2 [X] NO	OCCUPANT IN MOTOR VEHICLE ACCIDENT
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
	ON STREET		LONG BAR HARBOR RD.&RT40	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	O.C.M.E.	03-10-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

FRANK J. PERETTI, MD 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 11 '92	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09345

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Michael G. Palya Jr.				2. DATE OF DEATH: MONTH 3 DAY 22 YEAR 92	3. TIME OF DEATH: 2:52 AM
4. SOCIAL SECURITY NUMBER: 170-30-0735	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 55 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-16-36	8. BIRTHPLACE (State or Foreign Country): Penna.
9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown		9c. COUNTY OF DEATH: Balto.

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Reisterstown	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 103 Hanover Road		10f. ZIP CODE: 21136	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+ Yrs College	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Baltimore County Board of Education	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Michael G. Palya Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Lusczek	
19a. INFORMANT'S NAME (Type/Print): Mrs. Patricia A. Palya		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 Hanover Road Reisterstown, Md. 21136	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Memorial	DATE: 3/24	20c. LOCATION — City or Town, State: Finksburg, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James B Eline	22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home	11824 Reisterstown Rd. Reisterstown, Md. 21136	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Left Cerebral Vascular Accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: B Kutsche MD	29c. LICENSE NUMBER: D 35788	29d. DATE SIGNED (Month, Day, Year): 3/22/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): B. KUTSCHE MD Balt Co. General Hosp. 5401 Old Court Rd. Baltimore, MD

31. DATE FILED (Month, Day, Year): MAR 24 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09346

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Genevieve B. Peszynski			2. DATE OF DEATH (Month, Day, Year): March 22 1992	3. TIME OF DEATH: 5:05 A M
4. SOCIAL SECURITY NUMBER: 065-01-7995	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 20, 1912	8. BIRTHPLACE (State or Foreign Country): New Jersey
9a. FACILITY NAME (If not institution, give street and number): Cherrywood Manor Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Reisterstown	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: New Jersey	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Bayonne	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 22 W. 13th Street		10f. ZIP CODE: 07002	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY: Banking	
17. FATHER'S NAME (First, Middle, Last): Adam Sadowski		18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Demorat	
19a. INFORMANT'S NAME (Type/Print): Barbara M. Lake		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 237 Highmeadow Rd. Reisterstown, Md. 21136	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery	20c. LOCATION — City or Town, State: North Arlington, N.J.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Brian Powell		22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home 11824 Reisterstown Rd. Reisterstown, Md. 21136	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications thet ceused the death. Do not enter the mode of dying, auch as cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Breast cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly list conditions, if any, leading to immediete cause. Enter UNDERLYING CAUSE (Diseese or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia Alzheimers type; Arteriosclerotic Vascular Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residance 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gary Manko	29c. LICENSE NUMBER: D25062	29d. DATE SIGNED (Month, Day, Year): ▶ 3/23/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gary Manko, M.D. 11 E. Chestnut Hill Lane Reisterstown, Md. 21136

31. DATE FILED (Month, Day, Year): MAR 24 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09347

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Emily MCDaniel Peterson
2. DATE OF DEATH (Month, Day, Year): March 17, 1992
3. TIME OF DEATH: 0018 M
4. SOCIAL SECURITY NUMBER: 222-14-6008
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): April 24, 1907
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Union Hospital of Cecil County
9b. CITY, TOWN OR LOCATION OF DEATH: Elkton
9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Cecil
10c. CITY, TOWN OR LOCATION: Elkton
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 121 Hollingsworth Manor
10f. ZIP CODE: 21921
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Technician
16b. KIND OF BUSINESS/INDUSTRY: Sporting Goods Manufacturing
17. FATHER'S NAME (First, Middle, Last): Henry McDaniel
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rachel Jackson
19a. INFORMANT'S NAME (Type/Print): Marie Main
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 121 Hollingsworth Manor - Elkton, MD 21921
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cherry Hill Meth. Cemetery — DATE: 3-20 1992
20c. LOCATION — City or Town, State: Cherry Hill, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald S. Hicks
22. NAME AND ADDRESS OF FACILITY: Hicks Home for Funerals, PA 103 West Stockton Street Elkton, MD 21921-5521

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. HEART FAILURE + CARDIAC ARREST
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ACUTE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):
c. ASHD
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: P Pollner MD
29c. LICENSE NUMBER: D15717
29d. DATE SIGNED (Month, Day, Year): ▶ 3-17-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Philip Pollner, M.D. - 131 West Main Street - Elkton, MD 21921
31. DATE FILED (Month, Day, Year): MAR 19 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09348

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Cooley Price
2. DATE OF DEATH (Month, Day, Year): 3 18 92
3. TIME OF DEATH: 2355 M
4. SOCIAL SECURITY NUMBER: 218-14-9643
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/27/13
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Union Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Elkton
9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Cecil
10c. CITY, TOWN OR LOCATION: Chesapeake City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 48 Hessey Lane
10f. ZIP CODE: 21915
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk
16b. KIND OF BUSINESS/INDUSTRY: Southern States
17. FATHER'S NAME (First, Middle, Last): Charles Manlove Price
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth (no info)
19a. INFORMANT'S NAME (Type/Print): Anna P. Schrader
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 649 Biddle St., Chesapeake City, MD 21915
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bethel Cem. DATE: 3/21/92
20c. LOCATION — City or Town, State: Ches. City, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward McKown
22. NAME AND ADDRESS OF FACILITY: Gee Funeral Home, 259 E. Main St., Elkton, MD 21921

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Chronic Obstructive Pulmonary Disease — Approximate Interval: 5 yrs
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Recent CVA - rt. hemiplegia and relative aphasia, Ca of Prostate. Possible acute myocardial anemia due to respiratory failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Wallace Obenshain, MD
29c. LICENSE NUMBER: D07129
29d. DATE SIGNED (Month, Day, Year): 18 mar 92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Wallace Obenshain, M.D. Cecilton, md. 21913
31. DATE FILED (Month, Day, Year): MAR 23 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

3

92 09349

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JEROME POSEY			2. DATE OF DEATH (Month, Day, Year): MARCH 23, 1992	3. TIME OF DEATH: 6:10 AM M
4. SOCIAL SECURITY NUMBER: 213-40-9124	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 49 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7/22/1942	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: LA PLATA		9c. COUNTY OF DEATH: CHARLES
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Nanjemoy		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Rt. 1, Box 36, Gilroy Rd.		10f. ZIP CODE: 20662		10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Laborer		16b. KIND OF BUSINESS/INDUSTRY: Private
17. FATHER'S NAME (First, Middle, Last): Archie Posey			18. MOTHER'S NAME (First, Middle, Maiden Surname): Mascelia Gainor	
19a. INFORMANT'S NAME (Type/Print): Deloris Ellis Posey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt.1, Box 36, Gilroy Rd., Nanjemoy, Md. 20662		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt.Hope Church Cemetery, 3/25/92	DATE	20c. LOCATION — City or Town, State: Ironsides, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leon Thornton		22. NAME AND ADDRESS OF FACILITY: Thornton Funeral Home, Rural Route 1, Box 115, Pomonkey, Md. 20640		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or reepiratory arrest, shock, or heart failure. Llet only one ceuse on aech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Cardiac arrest	
Sequentielly list conditions, if any, leading to immedlete cause. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Cerebral vascular accident	
	c. DUE TO (OR AS A CONSEQUENCE OF): Diabetes Mellitus	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [/] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [/] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
T.M. Pace MD	D--22574	▶ 3/23/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TIMOTHY R. PACE MD. PO BOX 249 WALDORF MD. 20603

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 24 '92	Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09350

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CALVIN QUILLEN				2. DATE OF DEATH (Month, Day, Year): 3 7 92	3. TIME OF DEATH: 0015 M
4. SOCIAL SECURITY NUMBER: 212-03-2011	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 7, 1907	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Easton		9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Williamsburg, Hurlock		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5006 Williamsburg Road		10f. ZIP CODE: 21643		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specity Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic	16b. KIND OF BUSINESS/INDUSTRY: Mechanic/ Auto		
17. FATHER'S NAME (First, Middle, Last): John Quillen	18. MOTHER'S NAME (First, Middle, Maiden Surname): Nettie Wright			
19a. INFORMANT'S NAME (Type/Print): Katherine R. Quillen	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5006 Williamsburg Rd. Hurlock, Md. 21643			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery 3/9/92	DATE	20c. LOCATION — City or Town, State: Federalsburg, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY: Williamson Funeral Home Federalsburg, Md. 21632			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not entar tha mode of dying, such as cardiec or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximata Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Lethal Arrythmia
DUE TO (OR AS A CONSEQUENCE OF):
b. Acute MI
DUE TO (OR AS A CONSEQUENCE OF):
c. CAD
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.
Peptic Ulcer Disease
Type II DM
Chronic Brain SYNDROME

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Michael Lees MD	D42005	▶ 3/7/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael Lees, Queen Anne Medical Center, 400 Melvin Ave, Queenstown, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 12 '92	Julia Davidson-Randall

OHMH-16 Rev 1/89

92 09351

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit; Pages 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Lawson Raun			2. DATE OF DEATH: MONTH 3 DAY 9 YEAR 92	3. TIME OF DEATH: 335 P M
4. SOCIAL SECURITY NUMBER: 475 16 4309	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12.8.22.	8. BIRTHPLACE (State or Foreign Country): Minn
9a. FACILITY NAME (If not institution, give street and number): 73 Bunker Hill RD (at home)		9b. CITY, TOWN OR LOCATION OF DEATH: Warwick		9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: md	10b. COUNTY: Cecil.	10c. CITY, TOWN OR LOCATION: Warwick.	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 73 Bunker Hill Road		10f. ZIP CODE: 21912	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurse		16b. KIND OF BUSINESS/INDUSTRY: V.A. Hospital
17. FATHER'S NAME (First, Middle, Last): Edward Lawson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Isabel Fahrenbach
19a. INFORMANT'S NAME (Type/Print): James Raun		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as above
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Capitol Crematory	20c. LOCATION — City or Town, State: Dover, DE
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary B. Fellows		22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home, P.A. 226 E. Main St., Cecilton, MD 21913

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ca Bowel	3 1/4 mo
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD	29c. LICENSE NUMBER: D15714	29d. DATE SIGNED (Month, Day, Year): ▶ 3.10.92.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Henry Farhas MD. Northern Chesapeake Hospice 111 Howard st Elkton, Md 21921		
31. DATE FILED (Month, Day, Year): MAR 16 92	32. REGISTRAR'S SIGNATURE: Jeha Davidson-Randall	

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DNMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09352
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Nora May Reed
2. DATE OF DEATH: MONTH 2 DAY 29 YEAR 1992
3. TIME OF DEATH: 1:05PM M
4. SOCIAL SECURITY NUMBER: 220-32-7659
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-6-13
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital @ Easton
9b. CITY, TOWN OR LOCATION OF DEATH: Easton
9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Caroline
10c. CITY, TOWN OR LOCATION: Greensboro
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 2, Box 221A
10f. ZIP CODE: 21639
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th-graduate; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Domestic
17. FATHER'S NAME (First, Middle, Last): Oswald Harrison
18. MOTNER'S NAME (First, Middle, Maiden Surname): Bertie Faulkner Harrison
19a. INFORMANT'S NAME (Type/Print): James Reed
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2, Box 221A, Greensboro, MD 21639
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Greensboro Cemetery DATE: 3/4/92
20c. LOCATION — City or Town, State: Greensboro, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas K Helfenbein
22. NAME AND ADDRESS OF FACILITY: Fleegle-Helfenbein Funeral Home, 106 Sunset Ave., Greensboro, MD 21639

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CVA, (R) Brain	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus, Type II

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Kevin J. O'Keefe MD
29c. LICENSE NUMBER: D35259
29d. DATE SIGNED (Month, Day, Year): 3/2/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KEVIN J. O'KEEFE, MD. 606 Dutchmans Lane, Easton MD 21601
31. DATE FILED (Month, Day, Year): MAR 6 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09353

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 to 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hazel Rosenkning — HAZEL L. ROSEN		2. DATE OF DEATH (Month, Day, Year): 3 / 16 / 92	3. TIME OF DEATH: 5:25 P M
4. SOCIAL SECURITY NUMBER: 215-82-3940	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-24-1912 — 8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Golden Oaks Con. & Rehab Ctr	9b. CITY, TOWN OR LOCATION OF DEATH: Laurel	9c. COUNTY OF DEATH: Prince George	

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Howard.	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3707 Tustin Rd.	10f. ZIP CODE: 21042	10g. CITIZEN OF WHAT COUNTRY?: United States	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Harry McCabe, Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Katie Fach
19a. INFORMANT'S NAME (Type/Print): Norma Ballantine	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3707 Tustin Road, Ellicott City, Md. 21042

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park	20c. LOCATION — City or Town, State: Woodlawn, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry H. Witzke	22. NAME AND ADDRESS OF FACILITY: HARRY H. WITZKE FUNERAL HOME, 4112 Old Columbia Pike, Ellicott City, Md. 21043	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such ee cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Oneet end Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Pulmonary Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly liet conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute cholecystitis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Ascending Cholangitis	
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.
Peripheral Neuropathy; Congestive Heart Failure; Congestive Heart Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) and manner ee stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Neil Margolis MD	29c. LICENSE NUMBER: D25430	29d. DATE SIGNED (Month, Day, Year): ▶ 3/16/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): John Neil MARGOLIS 14333 Laurel Bowie Rd #307 Laurel, MD 20708		
31. DATE FILED (Month, Day, Year): MAR 19 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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92 09354

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BEATRICE LUCILE ROEDER				2. DATE OF DEATH (Month, Day, Year): MARCH 16 1992	3. TIME OF DEATH: 06:48A M
4. SOCIAL SECURITY NUMBER: 212-38-7248	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): MAY 5 1903	8. BIRTHPLACE (State or Foreign Country): PENNA.
9a. FACILITY NAME (If not institution, give street and number): MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND	9c. COUNTY OF DEATH: ALLEGANY
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: CUMBERLAND			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 808 TROST AVENUE		10f. ZIP CODE: 21502		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SCHOOL TEACHER/COUNCIL WOMAN		16b. KIND OF BUSINESS/INDUSTRY: CITY COUNCIL/TEACHER	
17. FATHER'S NAME (First, Middle, Last): JOHN W, WILLCOX				18. MOTHER'S NAME (First, Middle, Maiden Surname): JESSIE WILLCOX	
19a. INFORMANT'S NAME (Type/Print): ERICH C.W. ROEDER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RFD#6 BOX#83 ROMNEY, WEST VIRGINIA 26757			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HILLCREST CEMETERY	DATE: MARCH 18 1992	20c. LOCATION — City or Town, State: CUMBERLAND, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale L. Merritt		22. NAME AND ADDRESS OF FACILITY: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURRED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robustiano Barrera, Jr.	D14865	▶ 3-17-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBUSTIANO BARRERA, M.D. MEMORIAL MEDICAL BUILDING CUMBERLAND MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 18 1992	[illegible] Davidson-Kimble

DHMH-16 Rev 1/89

92 09355

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY JEAN REINHARD

2. DATE OF DEATH (Month, Day, Year): March 17, 1992

3. TIME OF DEATH: 05:22 A M

4. SOCIAL SECURITY NUMBER: 215-20-7235

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 67 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 08-01-1924

8. BIRTHPLACE (State or Foreign Country): MD

9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Center

9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland

9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: Allegany

10c. CITY, TOWN OR LOCATION: Cumberland,

10d. INSIDE CITY LIMITS?: ☒ 1 YES 2 ☐ NO

10e. STREET AND NUMBER: 840 Camden Avenue

10f. ZIP CODE: 21502

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+): 4

16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Director

16b. KIND OF BUSINESS/INDUSTRY: Health Dept.

17. FATHER'S NAME (First, Middle, Last): John Joseph Reinhard

18. MOTHER'S NAME (First, Middle, Maiden Surname): Ada Gleeson

19a. INFORMANT'S NAME (Type/Print): Miss Nancy Reinhard

19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 840 Camden Avenue Cumberland, MD 21502

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): SS Peter Paul Cemetery
DATE: 3-21

20c. LOCATION — City or Town, State: Cumberland, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James J Scarpelli

22. NAME AND AOORESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. EMPHYSEMA — DUE TO (OR AS A CONSEQUENCE OF): — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. HYPOXEMIA — DUE TO (OR AS A CONSEQUENCE OF):

c. EXACERBATION OF COPD — DUE TO (OR AS A CONSEQUENCE OF):

d. OLD ANGINA

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?: 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?: 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?: 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK?: 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James M Raver MD

29c. LICENSE NUMBER: D18769

29d. DATE SIGNED (Month, Day, Year): 3/20/92

30. NAME AND AOORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. James Raver Memorial Hospital Cumberland, MD. 21502

31. DATE FILED (Month, Day, Year): MAR 23 1992

32. REGISTRAR'S SIGNATURE: Linda Davidson-Randall

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DHMH-16 Rev 1/89

92 09356

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George W. Ross			2. DATE OF DEATH (Month, Day, Year): 03-21-92	3. TIME OF DEATH: 910 PM
4. SOCIAL SECURITY NUMBER: 216-18-8949	5. SEX: 1 ☐ M 2 ☐ F XX	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1/2/1925	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Residence- 614 Washington St.		9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge	9c. COUNTY OF DEATH: Dorchester	
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: Dor.	10c. CITY, TOWN OR LOCATION: Cambridge	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO	
10e. STREET AND NUMBER: 614 Washin gton St	10f. ZIP CODE: 21613	10g. CITIZEN OF WHAT COUNTRY?: USA		
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XX YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW 2	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clifton Perkens Hosp	16b. KIND OF BUSINESS/INDUSTRY: Guard/ Male Nurse		
17. FATHER'S NAME (First, Middle, Last): John H. Ross	18. MOTHER'S NAME (First, Middle, Maiden Surname): LEnora Johnson Ross			
19a. INFORMANT'S NAME (Type/Print): Bernice S. Ross (WIFE)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 614 Washington St Camb., Md. 21613			
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md.Vet.Cem. East. Shore	20c. LOCATION — City or Town, State: Rt# 2 Hurlock, Md 21643		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lewis H. Boardley	22. NAME AND ADDRESS OF FACILITY: L. H. Boardley F/H Cambridge, Md. 21613			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Prostate Ca	4 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Craig W Caldwell MD	D35622	3/23/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CRAIG W CALDWELL DORCHESTER GEN HOSP, CAMBRIDGE, MD 21613

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 24 '92	Julia Davidson-Randall

DHMH-16 Rev 1/89

92-1612-033 FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09357 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) ~~SABALBURO~~ LUISITO FLORES ~~FLORES~~ SABALBURO					2. DATE OF DEATH MONTH 3 DAY 19 YEAR 1992	3. TIME OF DEATH 4:15 PM
4. SOCIAL SECURITY NUMBER 223-53-3588	5. SEX 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) 22 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) Nov. 16, 1969	8. BIRTHPLACE (State or Foreign Country) Philippines
9a. FACILITY NAME (If not institution, give street and number) W.ACCOKECK ROAD		9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH PRINCE GEORGES
RESIDENCE OF DECEDENT						
10a. STREET AND NUMBER 1108 Netherland Court		10b. COUNTY	10c. CITY, TOWN OR LOCATION Virginia Beach		10f. ZIP CODE 23456	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STATE Virginia						10g. CITIZEN OF WHAT COUNTRY? Philippines
11. MARITAL STATUS 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Filipino			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+) 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Flight Instructor	16b. KIND OF BUSINESS/INDUSTRY Flight International Inc.			
17. FATHER'S NAME (First, Middle, Last) Bernardo D. Sabalburo, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname) Cecilia Linda Santiago Flores				
19a. INFORMANT'S NAME (Type/Print) Brother Christopher F. Sabalburo---		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1108 Netherland Court, Virginia Beach, Virginia 23456				
20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Colonial Grove Memorial Park DATE 3/25/92	20c. LOCATION — City or Town, State Virginia Beach, Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY Smith and Williams Funeral Home 4889 Princess Anne Road, Va. Beach, Va.23462				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MULTIPLE INJURIES	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. AIRPLANE ACCIDENT	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) WOODED AREA

27. MANNER OF DEATH 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) 3-19-1992	28b. TIME OF INJURY 2:20 PM	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED PLANE CRASH
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER MARIO F. GOLB, M.D.	29c. LICENSE NUMBER O.C.M.E.	29d. DATE SIGNED (Month, Day, Year) ▶ 3-20-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLB, M.D. 111 PENN STREET BALTIMORE MARYLAND 21201		
31. DATE FILED (Mo., Day, Year) MAR 31 1992	32. REGISTRAR'S SIGNATURE Jane Davidson-Randall	

DHMH-16 Rev 1/89

92 09358

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALVERDA MAE SWOPE — Alverda Swope
2. DATE OF DEATH: MONTH 3 DAY 20 YEAR 92
3. TIME OF DEATH: 5:30 PM
4. SOCIAL SECURITY NUMBER: 288-20-7773
5. SEX: 1 ☐ M 2 ☒ F — XX
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9-7-1919
8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): Southern MD Hosp. Center
9b. CITY, TOWN OR LOCATION OF DEATH: Clinton
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: CHARLES
10c. CITY, TOWN OR LOCATION: WALDORF
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO — XX
10e. STREET AND NUMBER: P.O.BOX 571
10f. ZIP CODE: 20604
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married — X; 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — XX; IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO — XX; Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th GRADE; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): WILLIAM YAHNERT
18. MOTHER'S NAME (First, Middle, Maiden Surname): VIOLA F. RADGER
19a. INFORMANT'S NAME (Type/Print): CHARLES E. SWOPE
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS #10
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation — X 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HUNTT CREMATORY — DATE: 3-24-92
20c. LOCATION — City or Town, State: WALDORF, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael O. Raymond
22. NAME AND ADDRESS OF FACILITY: AREHART FUNERAL HOME, INC. LA PLATA, MARYLAND 20646

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Ovarian Cancer

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Congestive heart failure

DUE TO (OR AS A CONSEQUENCE OF):

c. Atrial Fibrillation

DUE TO (OR AS A CONSEQUENCE OF):

d. Thrombocytopenia, Idiopathic.

PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO — XX
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D37588
29d. DATE SIGNED (Month, Day, Year): 3-21-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAFIK A. NASR. MD - 7501 Surratts Rd - clinton rd
31. DATE FILED (Month, Day, Year): MAR 23 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle

DNMN-18 Rev 1/89

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92 09359

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James P. STROMBERG				2. DATE OF DEATH (Month, Day, Year): 3 18 92	3. TIME OF DEATH: 0420A M
4. SOCIAL SECURITY NUMBER: 219-18-1885	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 04-28-24	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON, MD		9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 8966 Chapel Avenue		10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Policeman	16b. KIND OF BUSINESS/INDUSTRY: Balto. City Police Dept
17. FATHER'S NAME (First, Middle, Last): Aloysius Stromberg		18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Gannon	
19a. INFORMANT'S NAME (Type/Print): Nancy Stromberg		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8966 Chapel Avenue, Ellicott City, Md. 21043	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): New Cathedral DATE: 3/21/92	20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry H. Witzke		22. NAME AND ADDRESS OF FACILITY: HARRY H. WITZKE FUNERAL HOME 4112 OldColumbia Pike, Ellicott City, Md. 21043	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused tha daeth. Do not enter the mode of dying, such ee cerdiac or reepiratory erreet, ehock, or heert failure. List only one cauee on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	e. RESPIRATORY FAILURE	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if eny, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST	b. CARCINOMA OF THE PANCREAS.	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NONE

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner ee stated.
2 [ ] MEDICAL EXAMINER: On the baele of exemination and/or investigation, in my opinion, death occured at the time, date and place, end due to the ceuse(s) end menner ee stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] M.D.	29c. LICENSE NUMBER: D24025	29d. DATE SIGNED (Month, Day, Year) ▶ 3/18/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EDUARDO J. LAGUE 7620 York Rd, BAL. MD. 21204.

31. DATE FILED (Month, Day, Year): MAR 19 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 09360

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES Franklin SHANHOLTZ			2. DATE OF DEATH (Month, Day, Year): March 21, 1992	3. TIME OF DEATH: 1:45 P M
4. SOCIAL SECURITY NUMBER: 217-10-5553	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 25, 1910	8. BIRTHPLACE (State or Foreign Country): W. Va.
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: Allegany	
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: Rt. #3 Box 86 Bedford Road		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY: Textile		
17. FATHER'S NAME (First, Middle, Last): Clark Shanholtz	18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie Barrow			
19a. INFORMANT'S NAME (Type/Print): Mrs. Eva L. Shanholtz	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. #3 Box 86 Bedford Rd. Cumberland, Md. 21502			
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Zion Memorial Park	DATE: March 25, 1992	20c. LOCATION — City or Town, State: Cumberland, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert C. Adams	22. NAME AND ADDRESS OF FACILITY: Merritt-Adams Funeral Home 404 Decatur St. Cumberland, Md. 21502			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiopulmonary Arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Multiple CA's prostate	
DUE TO (OR AS A CONSEQUENCE OF): c.	Metastatic bone - multiple	
DUE TO (OR AS A CONSEQUENCE OF): d.	ASVD & CHF	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D 16041	29d. DATE SIGNED (Month, Day, Year): 3-22-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Terry Williams Memorial Hospital Medical Bldg. Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): MAR 23 1992	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

92 09361

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY JANE SMITH / MARY JANE SMITH
2. DATE OF DEATH (Month, Day, Year): 3-22-92 / 3 - 22 - 92
3. TIME OF DEATH: 12:25 PM / 12:25 PM
4. SOCIAL SECURITY NUMBER: 221-14-4809
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 68 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 04-12-23
8. BIRTHPLACE (State or Foreign Country): N J
9a. FACILITY NAME (If not institution, give street and number): Dorchester General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge
9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Dorchester
10c. CITY, TOWN OR LOCATION: Woolford
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: P O Box 75
10f. ZIP CODE: 21677
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES X
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Ernest Wilson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown Johnson
19a. INFORMANT'S NAME (Type/Print): William J. Smith
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 75 Woolford, Md. 21677
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Old Trinity Church
DATE: 3/26
20c. LOCATION — City or Town, State: Church Creek, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St Cambridge, Md 21613

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. BREAST CANCER METASTATIC to LUNG	3 MONTHS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. BREAST CANCER METASTATIC TO LUNG	3 MONTHS
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael A. Moskewicz MD
29c. LICENSE NUMBER: D-16609
29d. DATE SIGNED (Month, Day, Year): ▶ 3-22-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL A. MOSKEWICZ MD. 503 BURN ST. CAMBRIDGE MD

31. DATE FILED (Month, Day, Year): MAR 24 '92
32. REGISTRAR'S SIGNATURE: [signature] Davidson-Randall
21613

DHMH-16 Rev 1/89

92 09362

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 - 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret Etta Thompson		2. DATE OF DEATH (Month, Day, Year): March 9 1992	3. TIME OF DEATH: 2:40 A M
4. SOCIAL SECURITY NUMBER: 215-38-1472	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 24, 1936
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): 7631 Airy Hill Road	9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown	9c. COUNTY OF DEATH: Kent	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Kent	10c. CITY, TOWN OR LOCATION: Chestertown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7631 Airy Hill Road	10f. ZIP CODE: 21620	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementery/Secondary (0-12): 11th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic Work	16b. KIND OF BUSINESS/INDUSTRY: Private Families	
17. FATHER'S NAME (First, Middle, Last): George Henry Graves	18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Graves		
19a. INFORMANT'S NAME (Type/Print): William H. Thompson	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7631 Airy Hill Road, Chestertown, MD 21620		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Emmanuel Cemetery	20c. LOCATION — City or Town, State: Pomona, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James A. Perkins	22. NAME AND ADDRESS OF FACILITY: James A. Perkins Funeral Service P.O.Box 143, Rock Hall, Md. 21661		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumonia - Aspiration	1 month
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Carcinoma of pharynx	16 month
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: W. D Benjamin MD	29c. LICENSE NUMBER: D16488	29d. DATE SIGNED (Month, Day, Year): ▶ 3-10-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Wayne D Benjamin MD Medical Building Chestertown Md 21620		
31. DATE FILED (Month, Day, Year): MAR 10 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

5

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09363
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Francis Herbert Trice, Sr.
2. DATE OF DEATH (Month, Day, Year): 02 25 1992
3. TIME OF DEATH: 6:30 A M
4. SOCIAL SECURITY NUMBER: 197-09-5955
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 88 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10 8 1903
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): MD Route 404 Rt. 2 Box 23
9b. CITY, TOWN OR LOCATION OF DEATH: Denton
9c. COUNTY OF DEATH: Caroline

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Caroline
10c. CITY, TOWN OR LOCATION: Denton
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: MD Route 404 Rt. 2 Box 23
10f. ZIP CODE: 21629
10g. CITIZEN OF WHAT COUNTRY?: U.S. A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementery/Secondary (0-12): 4 yrs; College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist
16b. KIND OF BUSINESS/INDUSTRY: Machine
17. FATHER'S NAME (First, Middle, Last): Milton Trice
18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie Wright
19a. INFORMANT'S NAME (Type/Print): Phyllis T. Carroll
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1 Box 184, Ridgely, Maryland 21660
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Concord Cemetery
DATE: 2/29
20c. LOCATION — City or Town, State: Denton, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph L. Moore
22. NAME AND ADDRESS OF FACILITY: Moore Funeral Home, P.A. Drawer B, Denton, Maryland 21629

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Myocardial infarction — DUE TO (OR AS A CONSEQUENCE OF): — THR
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D 27409
29d. DATE SIGNED (Month, Day, Year): ▶ 2-28-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 606 Dutchmans Lane EASTON MD 21601
31. DATE FILED (Month, Day, Year): MAR 5 '92
32. REGISTRAR'S SIGNATURE: [signature] Randolph-Randall

DHMN-16 Rev 1/89

92 09364

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
IRENE E	TOWERS		2 28 92	01:45 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
214-34-5936	1 ☐ M 2 ☒ F	87 YRS.			08 16 1904	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Caroline Nursing Home	Denton	Caroline

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Caroline	Denton	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
206 North Sixth Street	21629	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
8 yrs	None	Homemaker	Home

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
No Record	Unknown

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles L. Davis	85 Sharp Road, Denton, Maryland 21629

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Concord Cemetery	3/2	Denton, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Richard W. Moore	Moore Funeral Home, P.A. Drawer B, Denton, Maryland 21629

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dementia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Anemia

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
James Sides	D3376	2-28-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

James Sides PO Box 496 Denton MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 5 '92	Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09365
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joanne D. Toomey					2. DATE OF DEATH (Month, Day, Year): March 4 1992	3. TIME OF DEATH: 7:08AM M
4. SOCIAL SECURITY NUMBER: 217-42-6142	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 48 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 08/01/43	8. BIRTHPLACE (State or Foreign Country): Delaware
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital at Easton					9b. CITY, TOWN OR LOCATION OF DEATH: Easton	9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Federalsburg	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 618 West Central Avenue		10f. ZIP CODE: 21632	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 1+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laboratory Tech.	16b. KIND OF BUSINESS/INDUSTRY: Research & Development Celeste Indust. Easton
17. FATHER'S NAME (First, Middle, Last): Delmar Holland		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Elizabeth Hall	
19a. INFORMANT'S NAME (Type/Print): Debra Lynn Bradley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 187 Meadowbrook Park, Federalsburg, MD	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bridgeville Cemetery	DATE: 7
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael F. Eskow		22. NAME AND ADDRESS OF FACILITY: Framptom-Hawkins-Eskow Funeral Home PO Bx 43, Federalsburg, MD 21632	20c. LOCATION — City or Town, State: Bridgeville, DE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetions that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Small cell lung Cancer — DUE TO (OR AS A CONSEQUENCE OF):	12 Month
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. — DUE TO (OR AS A CONSEQUENCE OF):	
	c. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	26e. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
	26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: DHSmith	29c. LICENSE NUMBER: D39887	29d. DATE SIGNED (Month, Day, Year) ▶ 3/5/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. David H. Smith, M.D., 509 Idlewild Ave., Easton, MD 21601		
31. DATE FILED (Month, Day, Year): MAR 11 92	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

DHMH-16 Rev 1/89

92 09366

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Linda Tucker				2. DATE OF DEATH (Month / Day / Year): 03 / 11 / 92	3. TIME OF DEATH: 10:20a M
4. SOCIAL SECURITY NUMBER: 219-70-7870	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 32 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 07/28/59	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): University Maryland Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Henderson	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 1, Box 89B		10f. ZIP CODE: 21640	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nursing Assistant	16b. KIND OF BUSINESS/INDUSTRY: Medical	
17. FATHER'S NAME (First, Middle, Last): Edward Brown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Betty Cannon Flagle	
19a. INFORMANT'S NAME (Type/Print): Doris Coulby		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Stockton Dr., New Castle, DE 19720	

20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olive Cemetery	DATE: 3/14/92	20c. LOCATION — City or Town, State: Felton, DE
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Fleegle-Helfenbein Funeral Home 106 Sunset Ave., Greensboro, MD 21639	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute myelogenous leukemia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Overwhelming Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Sweets Syndrome	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Renal Failure	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kerven Elderma House officer		29c. LICENSE NUMBER: D38993	29d. DATE SIGNED (Month, Day, Year): ▶ 3/11/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kerven Elderma 22 S. Greene st Balt. M.D. 21201			
31. DATE FILED (Month, Day, Year): MAR 17 92	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall		

DNMH-16 Rev 1/89

92-1626-025

92 09367

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DENNIS LEE TRICE (Dennis Lee Trice)			2. DATE OF DEATH (Month, Day, Year): 03 19 1992	3. TIME OF DEATH: 9:58 PM
4. SOCIAL SECURITY NUMBER: 215-68-5080	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 35 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 7, 1956	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1454 HEAPS ROAD		9b. CITY, TOWN OR LOCATION OF DEATH: WHITEFORD		9c. COUNTY OF DEATH: HARFORD
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Whiteford		10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1454 Heaps Road		10f. ZIP CODE: 21160		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Logger		16b. KIND OF BUSINESS/INDUSTRY: Wood Harvesting
17. FATHER'S NAME (First, Middle, Last): William David Trice			18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ellen Grant	
19a. INFORMANT'S NAME (Type/Print): Mary E. Teryek		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 929 Rumsey Place, Joppa, Md. 21085		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Harford Memorial Gardens DATE: 3-23-92		20c. LOCATION — City or Town, State: Aldino, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Intraoral Shotgun wound	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	03-19-1992	9:58P M	1 [ ] YES 2 [X] NO	SELF INFLICTED GUNSHOT WOUND
	29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
	AT HOME			1454 HEAPS ROAD

29e. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Clayton Locke MD	O.C.M.E.	▶03-20-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CLARON LOCKE, MD 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 23 '92	Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09368

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DI.

(a. Last) ca Thomas				2. DATE OF DEATH MONTH 03 DAY 15 YEAR 92	3. TIME OF DEATH 1505 P M
UMBER 1-2473	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 8-30-1900	8. BIRTHPLACE (State or Foreign Country) Pennsylvania
NAME (If not institution, give street and number) on's Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Allegany	Cumberland	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Formerly of Pulaski Street	21502	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Merried 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12) 12	College (1-4 or 5 +)	Municipal Ins. Co.	Insurance

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Henry J. Livengood	Mary Ellen Shoemaker

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda Parsons	Rt.3 Box 119 Cumberland,Md. 21502

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	St. Paul's Cemetery	3/17/92	Addison, Penna.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Ernest A. Riley, Jr.	Leasure-Stein, Inc. 230 Baltimore Av. Cumberland, Md. 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular accident - left. c seizures.

OUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C.O.P.D c acute exacerbation, Diabetis Mellitus

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
V.A. Ranjithan M.D.	D19750	▶ 3-16-92.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

V.A. Ranjithan, M.D. Lions Manor Nursing Home Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 17 1992	

OHMH-16 Rev 1/89

92 09369

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDITH C. TICHNELL					2. DATE OF DEATH — MONTH: March DAY: 16 YEAR: 1992		3. TIME OF DEATH: 1:00 a.m.
4. SOCIAL SECURITY NUMBER: 214-74-0248	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Oct. 23 1899		8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): Dennitt Manor Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Oakland			9c. COUNTY OF DEATH: Garrett	
RESIDENCE OF DECEDENT							
10a. STATE: Md.	10b. COUNTY: Garrett		10c. CITY, TOWN OR LOCATION: Swanton			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: RFD 1 , Chestnut Grove Road			10f. ZIP CODE: 21561			10g. CITIZEN OF WHAT COUNTRY? US	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced XX	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO X — IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO — Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife			16b. KIND OF BUSINESS/INDUSTRY: Domestic	
17. FATHER'S NAME (First, Middle, Last): George S. Taylor			18. MOTHER'S NAME (First, Middle, Maiden Surname): Rachel Warnick				
19a. INFORMANT'S NAME (Type/Print): Raymond Tichnell			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RFD 1 Chestnut Grove, Swanton, Md. 21561				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Turner Cemetery — DATE: 3-18-92			20c. LOCATION — City or Town, State: Swanton Md. 21561	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Frederick W Warnick			22. NAME AND ADDRESS OF FACILITY: Boal-Warnick Funeral Home 111 Church St. Westernport, Md. 21562				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cancer of the Ovary	3 mo.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO X	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO X	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Karl E. Schwalm MD	D27205	▶ 3/17/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Karl E. Schwalm 311 N. 4th St., Oakland, MD 21550

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 19 1992	Joan Davidson-Randall

2

DHMH-16 Rev 1/89

92 09370

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD M. TOMLINSON, SR.			2. DATE OF DEATH (Month): 3/20/92 (Year)	3. TIME OF DEATH: 10:00 A.M
4. SOCIAL SECURITY NUMBER: 579-14-1914	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 4-11-1909
8. BIRTHPLACE (State or Foreign Country): Maryland				
9a. FACILITY NAME (If not institution, give street and number): 1509 Rollins Avenue	9b. CITY, TOWN OR LOCATION OF DEATH: Capitol Heights	9c. COUNTY OF DEATH: Prince Georges		

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Capitol Heights	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1509 Rollins Avenue	10f. ZIP CODE: 20743	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter	16b. KIND OF BUSINESS/INDUSTRY: Construction	
17. FATHER'S NAME (First, Middle, Last): John C. Tomlinson	18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Garner		
19a. INFORMANT'S NAME (Type/Print): Edward Tomlinson, Jr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 163 Konrad Morgan Way, Lothian, MD 20711		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery; DATE: 3-24	20c. LOCATION — City or Town, State: Cheltenham, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Benjamin Matthews M00658	22. NAME AND ADDRESS OF FACILITY: HUNTT Funeral Home, P. O. box 156, Waldorf, Md. 20604-0156		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MYOCARDIAL INFARCTION	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D19431	29d. DATE SIGNED (Month, Day, Year): 3/20/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. F. RYAN 6188 OXON HILL ROAD, OXON HILL, MD 20745		
31. DATE FILED (Month, Day, Year): MAR 24 92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

Item4 3-30-92 FilmG686 W.H. Per Health Dept

92 09371

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): STANLEY JOSEPH VAITES
2. DATE OF DEATH — MONTH: 03 DAY: 21 YEAR: 92
3. TIME OF DEATH: 3:35 PM
4. SOCIAL SECURITY NUMBER: 187-18-8574
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/8/23
8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): Union Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Elkton
9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: PA
10b. COUNTY: Delaware
10c. CITY, TOWN OR LOCATION: Glenolden,
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1021 Lannton Terrace
10f. ZIP CODE: 19036
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: Army, WWII
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer
16b. KIND OF BUSINESS/INDUSTRY: MAINTENANCE
17. FATHER'S NAME (First, Middle, Last): Anthony Vaites
18. MOTHER'S NAME (First, Middle, Maiden Surname): Veronica Toulowick
19a. INFORMANT'S NAME (Type/Print): Edward B. Russell F.H.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 995 Fayette St., Conshohocken, PA 19428
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Valley Forge Mem. Gard. — DATE: 3/25/92
20c. LOCATION — City or Town, State: Uppermerion, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward McGowan
22. NAME AND ADDRESS OF FACILITY: Gee Funeral Home, 259 E. Main St., Elkton, MD 21921

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Myocardial Infarction	5-10 min
DUE TO (OR AS A CONSEQUENCE OF): b.	Hypertension	8-10 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: High cholesterol & triglycerides

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Ted Brunion M.D.
29c. LICENSE NUMBER: D26407
29d. DATE SIGNED (Month, Day, Year): 3/21/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): MAR 23 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09372

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anton Randolph Vonberg

2. DATE OF DEATH Month: 3 Day: 10 Year: 92

3. TIME OF DEATH: 8:30p. M

4. SOCIAL SECURITY NUMBER: 203 - 10 - 9261

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 80 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Feb 4, 1912

8. BIRTHPLACE (State or Foreign Country): Pennsylvania

9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Beltsville Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Laurel

9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Burtonsville

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 14516 Wexhall Terrace

10f. ZIP CODE: 20866

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEOENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): Grade 9
College (1-4 or 5+):

16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Trailer Machinist

18b. KIND OF BUSINESS/INDUSTRY: Trailer Garage

17. FATHER'S NAME (First, Middle, Last): Peter William Von Berg

18. MOTHER'S NAME (First, Middle, Maiden Surname): Katharina Marie

19a. INFORMANT'S NAME (Type/Print): Katharina Marie Vivian

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14516 Wexhall Terrace, Burtonsville, Maryland 20866

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE AND OATE OF DISPOSITION (Name of cemetary, crematory or other place): Pine Grove Memorial

OATE: 3/13

20c. LOCATION — City or Town, State: Hapboro, Pennsylvania

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]

22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home, P.A.
313 Talbott Ave. Laurel, Maryland 20707

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Sepsis	Days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	metabolic acidosis	Days
DUE TO (OR AS A CONSEQUENCE OF):		
c.	COPD	Yrs
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: Anemia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

26a. DATE OF INJURY (Month, Day, Year)

26b. TIME OF INJURY M

26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D28998

29d. DATE SIGNED (Month, Day, Year): ▶ 3-11-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PRITAM SSAINI MD 9101 Cherry Ln #2 Laurel MD 20708

31. DATE FILED (Month, Day, Year): MAR 12 '92

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09373

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GARRY WHIBLE			2. DATE OF DEATH (Month, Day, Year): 03-12-92	3. TIME OF DEATH: 7:05 a.M
4. SOCIAL SECURITY NUMBER: 136-18-7915	5. SEX: 1 [X] M 2 [ ] F	8. AGE (In yrs. last birthday): 95 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec 27, 1896	8. BIRTHPLACE (State or Foreign Country): New Jersey
9a. FACILITY NAME (If not institution, give street and number): Rt. 1, Box 24A, Barclay (home)		9b. CITY, TOWN OR LOCATION OF DEATH: Barclay		9c. COUNTY OF DEATH: Q.A.
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Q.A.	10c. CITY, TOWN OR LOCATION: Barclay		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Rt. 1, Box 24A		10f. ZIP CODE: 21607		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): conductor		16b. KIND OF BUSINESS/INDUSTRY: Trolley Car
17. FATHER'S NAME (First, Middle, Last): Abe Whible		18. MOTHER'S NAME (First, Middle, Maiden Surname): Estella Jones		
19a. INFORMANT'S NAME (Type/Print): Mary Whible		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as above		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Capitol Crematory	DATE: 3/12/92	20c. LOCATION — City or Town, State: Dover, DE
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary B Fellows		22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home, P.A. 370 W. Cypress ST, Millington, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction	MIN.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerotic Heart Disease	Years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: W. D. Benjamin	29c. LICENSE NUMBER: D16488	29d. DATE SIGNED (Month, Day, Year): 3/12/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Wayne D. Benjamin M.D., Chestertown, MD 21620		
31. DATE FILED (Month, Day, Year): MAR 16 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

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DHMH-18 Rev 1/89

92 09374

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eleanora D. Wise			2. DATE OF DEATH (Month, Day, Year): 3 22 92	3. TIME OF DEATH: 1145 P M
4. SOCIAL SECURITY NUMBER: 215-44-0698	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 01-01-04	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Long View Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Manchester		9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Hampstead	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 4201 Black Rock Rd.		10f. ZIP CODE: ~~21107~~ 21074	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Clifton Murray		18. MOTHER'S NAME (First, Middle, Maiden Surname): Georgia Ash	
19a. INFORMANT'S NAME (Type/Print): Helen Utz		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4201 Black Rock Rd. Hampstead Md. ~~21107~~ 21074	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation Services	20c. LOCATION — City or Town, State: Hampstead, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R Lacy Nightingale		22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home 934 S. Main Street, Hampstead, Md. 21074	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of breast with metastasis	2yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: arteriosclerotic Heart Disease

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: W H Foard MD	29c. LICENSE NUMBER: D02386	29d. DATE SIGNED (Month, Day, Year): ▶ 3/24/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): W H Foard MD 3223 Main St - Manchester, Md 21102		
31. DATE FILED (Month, Day, Year): MAR 24 '92	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall	

DHMH-16 Rev 1/89

92-1350-025

92 09375

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT IRVING WALLS JR.				2. DATE OF DEATH (Month, Day, Year): 03 09 1992	3. TIME OF DEATH: 8:45 P.M
4. SOCIAL SECURITY NUMBER: 213-90-6353	5. SEX: [X] 1 M [ ] 2 F	6. AGE (In yrs. last birthday): 17 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 21, 1974	8. BIRTHPLACE (State or Foreign Country): Alaska
9a. FACILITY NAME (If not institution, give street and number): LONG BAR HARBOR ROAD			9b. CITY, TOWN OR LOCATION OF DEATH: ABINGDON		9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Abingdon	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3405 Brooks Avenue		10f. ZIP CODE: 21009	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: [X] 1 Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student	16b. KIND OF BUSINESS/INDUSTRY: High School	
17. FATHER'S NAME (First, Middle, Last): Robert Irving Walls, Sr.		16. MOTHER'S NAME (First, Middle, Maiden Surname): Linda Carole Pugh	
19a. INFORMANT'S NAME (Type/Print): Linda C. Walls		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3405 Brooks Avenue, Abingdon, Md. 21009	

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bel Air Memorial Gardens	DATE: 3-12-92	20c. LOCATION — City or Town, State: Bel Air, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple Injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? [X] 1 YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify): LONG BAR HARBOR RD.		
27. MANNER OF DEATH: 1 [X] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 03-09-1992	28b. TIME OF INJURY: 6:25P.M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: DRIVER IN AUTO/AUTO IMPACT
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): ON ROAD			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): LONG BAR HARBOR ROAD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶03-10-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK J. PONTIUS	111 PENN STREET BALTIMORE MARYLAND 21201	
31. DATE FILED (Month, Day, Year): MAR 11 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

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92 09376

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Barry Webster			2. DATE OF DEATH — MONTH: 3 DAY: 10 YEAR: 92	3. TIME OF DEATH: 9:30 A M	
4. SOCIAL SECURITY NUMBER: 218-12-4143	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5-27-25	8. BIRTHPLACE (State or Foreign Country): Virginia-	
9a. FACILITY NAME (If not institution, give street and number): 107 B East Broadway		9b. CITY, TOWN OR LOCATION OF DEATH: Bel Air		9c. COUNTY OF DEATH: Harford	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Bel Air	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 107-B East Broadway		10f. ZIP CODE: 21014	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tractor Sales	16b. KIND OF BUSINESS/INDUSTRY: Tractor-Equipment	
17. FATHER'S NAME (First, Middle, Last): Joseph Ignatius Webster		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nan Miriam Poole	
19a. INFORMANT'S NAME (Type/Print): Harry V. Webster		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3414 Walnut Road, Aberdeen, Md. 21001	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory, or other place): St. Ignatius Cemetery DATE: 3-14-92	20c. LOCATION — City or Town, State: Hickory, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Asst. Med Examiner Richard J. Colfer MD	29c. LICENSE NUMBER: DO 1194	29d. DATE SIGNED (Month, Day, Year): 3/10/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD J. COLFER, M.D. 2013 Trappe Church Rd Darlington, Md. 21034		
31. DATE FILED (Month, Day, Year): MAR 11 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09377

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Samuel Marshall Ward
2. DATE OF DEATH (Month, Day, Year): 02/19/92
3. TIME OF DEATH: UNKNOWN M
4. SOCIAL SECURITY NUMBER: 164-10-5847
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 07/08/03
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Rt. 1, P.O. Box 33
9b. CITY, TOWN OR LOCATION OF DEATH: Henderson
9c. COUNTY OF DEATH: Caroline

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Caroline
10c. CITY, TOWN OR LOCATION: Henderson
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: Rt. 1, P.O. Box 33
10f. ZIP CODE: 21640
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Caster
16b. KIND OF BUSINESS/INDUSTRY: Industrial
17. FATHER'S NAME (First, Middle, Last): Samuel Marshall Ward, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary (unknown) Ward
19a. INFORMANT'S NAME (Type/Print): Samuel Ward
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 111, Marydel, MD 21649
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Greensboro Cemetery — DATE: 2/28/92
20c. LOCATION — City or Town, State: Greensboro, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Hugh C Keegle
22. NAME AND ADDRESS OF FACILITY: Fleegle-Helfenbein Funeral Home, 106 Sunset Ave., Greensboro, MD 21639

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBROVASCULAR ACCIDENT — ACUTE

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): b. ARTERIOSCLEROSIS

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: PREVIOUS cerebrovascular ACCIDENT

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: C.E. Jensen MD Deputy ME
29c. LICENSE NUMBER: D14664
29d. DATE SIGNED (Month, Day, Year): 29 Feb 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C.E. JENSEN MD, Rt 1, Box 118, DENTON MD 21629
31. DATE FILED (Month, Day, Year): MAR 3 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson Rendell

DHMH-18 Rev 1/89

92-1450-001

92 09378

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SHELLY LYNN WINE			2. DATE OF DEATH: MONTH 03 DAY 13 YEAR 92	3. TIME OF DEATH: 6:55 P M
4. SOCIAL SECURITY NUMBER: 233-35-1128	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 3 YRS. (IF UNDER 1 YEAR: MONTHS; DAYS; IF UNDER 24 HRS.: HOURS; MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 3,1988	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): CUMBERLAND MERORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND	9c. COUNTY OF DEATH: ALLEGANY	
RESIDENCE OF DECEDENT				
10a. STATE: WV	10b. COUNTY: Hampshire	10c. CITY, TOWN OR LOCATION: Burlington	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: Rt. 1, Box 46		10f. ZIP CODE: 26710	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO X Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): None; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None	16b. KIND OF BUSINESS/INDUSTRY: N/A		
17. FATHER'S NAME (First, Middle, Last): Roger D. Wine		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen L. Kennan		
19a. INFORMANT'S NAME (Type/Print): Roger D. Wine		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 46, Burlington, WV 26710		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) X	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): High Cemetery 3/16/92	DATE	20c. LOCATION — City or Town, State: Purgitsville, WV	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sarah S. Moyer		22. NAME AND ADDRESS OF FACILITY: Shaffer Funeral Home, Inc. 230 East Main St., Romney, WV 26757		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Mechanical Asphyxia and Suffocation	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO X	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 03/12/92	28b. TIME OF INJURY: 2:00 PM	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO XX
	28d. DESCRIBE HOW INJURY OCCURED: DIRT FELL ON THE SUBJECT		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): FARM	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): RTE.1,BURLINGTON,W.VA.	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis J. Chute MD	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶03/14/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dennis J. Chute M.D. 111 PENN STREET,BALTIMORE,MARYLAND 21201		
31. DATE FILED (Month, Day, Year): MAR 17 1992	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall	

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DHMH-16 Rev 1/89

92 09379

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HALLIE CATHERINE WASHINGTON
2. DATE OF DEATH (Month, Day, Year): 3 - 18-92
3. TIME OF DEATH: 1:00 AM
4. SOCIAL SECURITY NUMBER: 216 22 5799
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 17, 1910
8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: WV
10b. COUNTY: Hampshire
10c. CITY, TOWN OR LOCATION: Springfield
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: P. O. Box 34
10f. ZIP CODE: 26763
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Hite Washington
18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha McGruder
19a. INFORMANT'S NAME (Type/Print): Dolores Ann Thomas
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 913 Jefferson St. N.E. Washington, D.C. 20011
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Springfield Hill Cemetery — DATE: 3/21/92
20c. LOCATION — City or Town, State: Springfield, WV
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark Shaffer
22. NAME AND ADDRESS OF FACILITY: Shaffer Funeral Home, Inc. 230 East Main St., Romney, WV 26757

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pneumonia, acute (Probable Aspiration)
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dehydration
Malnutrition
Probable Occult Carcinoma - Unknown

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gary Wagoner MD
29c. LICENSE NUMBER: D22181
29d. DATE SIGNED (Month, Day, Year): 3-18-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. GARY WAGONER, M.D., 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502
31. DATE FILED (Month, Day, Year): MAR 23 1992
32. REGISTRAR'S SIGNATURE: Alice Davidson-Randall

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DHMH-16 Rev 1/99

92 09380

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William WILLIAM I Wing Wing			2. DATE OF DEATH (Month / Day / Year): 3 / 22 / 1992	3. TIME OF DEATH: 7:22 PM M
4. SOCIAL SECURITY NUMBER: 217-30-7696	5. SEX: 1 ☐ M 2 ☐ F XX	6. AGE (In yrs. last birthday): 57 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9/15/34	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Dorchester Gen. Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH: Camb.,		9c. COUNTY OF DEATH: Dor.

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Dor	10c. CITY, TOWN OR LOCATION: Cambridge	10d. INSIDE CITY LIMITS? XX 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 616 Cross St.		10f. ZIP CODE: 21613	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Russell Wing		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hennie Harris Wing	
19a. INFORMANT'S NAME (Type/Print): William Beasley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 725 Cornish Dr. Camb., Md. 21613	

20a. METHOD OF DISPOSITION: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Christ Rock Cem.	DATE: 3/25/92	20c. LOCATION — City or Town, State: Rock Rock, Md. 21613
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lewis H. Boardley		22. NAME AND ADDRESS OF FACILITY: L.H. Boardley F/H 812 Hubbard St. Camb., Md. 21613	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Seizure

DUE TO (OR AS A CONSEQUENCE OF): b. Respiratory Arrest

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. COPD

DUE TO (OR AS A CONSEQUENCE OF): d. Cor Pulmonale

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Alcoholism

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M J Faddem MD	29c. LICENSE NUMBER: D26388	29d. DATE SIGNED (Month, Day, Year) ▶ 3-22-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael J Faddem MD 302 @ 11 Ins Hurlock Md 21643

31. DATE FILED (Month, Day, Year): MAR 24 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Thomas Young	2. DATE OF DEATH (Month, Day, Year): 03 20 1992	3. TIME OF DEATH: 12:55 M	
4. SOCIAL SECURITY NUMBER: 213-05-1386	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 02-11-1910
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Westminster	9c. COUNTY OF DEATH: Carroll	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 807 Fairfield Avenue	10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor	16b. KIND OF BUSINESS/INDUSTRY: Grocery Store	
17. FATHER'S NAME (First, Middle, Last): Benjamin Thaddeus Young	18. MOTHER'S NAME (First, Middle, Maiden Surname): Charlotte Rothenberger		
19a. INFORMANT'S NAME (Type/Print): Bettie Beauchamp	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 807 Fairfield Ave, Westminster, MD 21157		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. John Catholic Cemetery	20c. LOCATION — City or Town, State: Westminster, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert A. Myers	22. NAME AND ADDRESS OF FACILITY: Myers Funeral Home 91 Willis Street, Westminster, MD 21157		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. cardiorespiratory arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. severe hypoxemia — days
DUE TO (OR AS A CONSEQUENCE OF):
c. Pneumonia, contained mucus — day
DUE TO (OR AS A CONSEQUENCE OF):
d. Left Sub Diaphragmatic Abscess — days

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.
arteriosclerotic cardiovascular disease, massive CVA recurrent congestive heart failure, colon cancer

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Ephraim Barzaga	D14992	▶ 3-20-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): EPHRAIM BARZAGA — Box 190 MEW. WINDSOR, Md. 21776

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 23 '92	Julia Davidson Randall

DHMH-16 Rev 1/89

92 09382

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Young, Mable			2. DATE OF DEATH (Month, Day, Year): 3 5 92	3. TIME OF DEATH: 540 A M
4. SOCIAL SECURITY NUMBER: 218-26-9157	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb 10, 1910	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 260 Wards Hill Road (at home)		9b. CITY, TOWN OR LOCATION OF DEATH: Cecilton		9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: Cecil County	10c. CITY, TOWN OR LOCATION: Cecilton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 260 Wards Hill Rd.	10f. ZIP CODE: 21913		10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Robert Gasaway	18. MOTHER'S NAME (First, Middle, Maiden Surname): Goldie Williams		
19a. INFORMANT'S NAME (Type/Print): Robert Young	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 School House Lane, Georgetown, MD		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bethel Cemetery	20c. LOCATION — City or Town, State: Cecilton, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary B. Fellows	22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home, P.A. 226 E. Main St., Cecilton, MD 21913		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Colon CA	18 years.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H Forkas MD	29c. LICENSE NUMBER: D15314	29d. DATE SIGNED (Month, Day, Year): ▶ 3/5/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H. Forkas, MD, Northern Chesapeake Hospice, 111 Howard St., Elkton MD

31. DATE FILED (Month, Day, Year): MAR 16 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

4

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09383

1 - FOR STATE REGISTRAR GEORGE SIMON ALLULIS

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE SIMON ALLULIS
2. DATE OF DEATH — MONTH: 4 DAY: 3 YEAR: 92
3. TIME OF DEATH: 3:55 @
4. SOCIAL SECURITY NUMBER: 215-07-8454
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 89 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-12-02
8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): HOWARD Co. GENERAL HOSP
9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA
9c. COUNTY OF DEATH: HOWARD

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: CATONSVILLE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1905 FREDERICK ROAD
10f. ZIP CODE: 21228
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRINTER
16b. KIND OF BUSINESS/INDUSTRY: U.S.F. & G.
17. FATHER'S NAME (First, Middle, Last): SIMON ALLULIS
18. MOTHER'S NAME (First, Middle, Maiden Surname): AGATHA SAULAIUS
19a. INFORMANT'S NAME (Type/Print): MARY AGNES CAMPBELL (DAUGHTER)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1905 FREDERICK ROAD CATONSVILLE MARYLAND 21228
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NEW CATHEDRAL CEMETERY 4/9/92
20c. LOCATION — City or Town, State: BALTIMORE MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE
22. NAME AND ADDRESS OF FACILITY: LEROY & RUSSELL WITZKE FUNERAL HOME 1630 EDMONDSON AVENUE CATONSVILLE MD. 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Chronic Obstructive Pulmonary Disease

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers Dementia
Septic Decubitus @ great trochanter

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Scott Maurer MD
29c. LICENSE NUMBER: D29909
29d. DATE SIGNED (Month, Day, Year): 4/3/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SCOTT MAURER 9501 ANNAPOLIS RD ELLICOTT CITY MD 21042
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

N

92 09384

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FELICITO APONTE (Felicito Aponte)			2. DATE OF DEATH (Month, Day, Year): 04 03 92	3. TIME OF DEATH: 12 57 AM
4. SOCIAL SECURITY NUMBER: 052141559	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 01-24-1912	8. BIRTHPLACE (State or Foreign Country): Puerto Rico
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 222 South Broadway		10f. ZIP CODE: 21231	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ YES 2 ☐ NO Specify: Puerto Rican	14. RACE — American Indian, Black, White, etc. Specify:

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 Yrs; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Merchant Marine	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Hemenegildo Aponte		18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Rosario	
19a. INFORMANT'S NAME (Type/Print): Miguel E. Aponte		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 222 S. Broadway Baltimore, MD 21231-2405	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Puerto Rico National Cemetery DATE	20c. LOCATION — City or Town, State: Bayamon, Puerto Rico
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Elizabeth Selenski		22. NAME AND ADDRESS OF FACILITY: Lilly & Zeiler, Inc. Funeral Home 1901 Eastern Ave. Balto., MD 21231	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. INTRACTABLE HEART FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF): SEPSIS.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph Quinto MD	29c. LICENSE NUMBER: D49903	29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH QUINTO MD 100 N BROADWAY BALTIMORE		
31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

92 09385

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARQUIS JOHN LAWRENCE BROOKMAN			2. DATE OF DEATH: Month April Day 2, Year 1992	3. TIME OF DEATH: 4:45 A M
4. SOCIAL SECURITY NUMBER: 192-05-6303	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): 1-22-1909	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: ROSSVILLE		9c. COUNTY OF DEATH: Baltimore County
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: ESSEX		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 618 NORRIS LANE		10f. ZIP CODE: 21221		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 10TH GRADE — College (1-4 or 5+): N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SHIPPING CLERK		16b. KIND OF BUSINESS/INDUSTRY: SEARS ROEBUCK AND COMPANY
17. FATHER'S NAME (First, Middle, Last): JOHN EDWARD BROOKMAN		18. MOTHER'S NAME (First, Middle, Maiden Surname): OLIVE BURKETT		
19a. INFORMANT'S NAME (Type/Print): NANCY LEE McKINNEY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7226 MARTELL AVENUE BALTIMORE, MARYLAND 21222		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HOLLY HILL MEMORIAL — DATE: 4-4-1992	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Chas W Tate	22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Sepsis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Peripheral Anterial Thrombosis

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	N/A	4/2/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jason Tate, MD 9000 Franklin Square Drive Baltimore, Maryland 21237

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 06 1992	Julia Davidson-Randall

DHMH-18 Rev 1/89

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92 09386

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lily (Lillie) Butler

2. DATE OF DEATH — Month: 4 Day: 1 Year: 1992

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 215-16-2415

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 73 YRS.

IF UNDER 1 YEAR — MONTHS: DAYS: IF UNDER 24 HRS. — HOURS: MIN.:

7. DATE OF BIRTH (Month, Day, Year): 11-22-1918

8. BIRTHPLACE (State or Foreign Country): Md

9a. FACILITY NAME (If not institution, give street and number): 2757 W, North Avenue

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 2757 W. North Avenue

10f. ZIP CODE: 21216

10g. CITIZEN OF WHAT COUNTRY?: U S A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)

16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Clarence Williams

18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Winstead

19a. INFORMANT'S NAME (Type/Print): Vanessa Johnson

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3309 Forest Park Avenue Baltimore, Md 21216

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial Park — DATE: 4692

20c. LOCATION — City or Town, State: Randallstown, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sala March

22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Avenue

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Myocardial Infarction — 1yr

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Coronary myopathy — 3/27/91

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): N/A

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Louis N. Randall MD

29c. LICENSE NUMBER: D17097

29d. DATE SIGNED (Month, Day, Year): 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Louis N. Randall MD 2300 Greenspring Blvd. Balto. 21216

31. DATE FILED (Month, Day, Year): APR 06 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09387

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Stanley W. Boswell, Jr
2. DATE OF DEATH (Month, Day, Year): 4 1 1992
3. TIME OF DEATH:
4. SOCIAL SECURITY NUMBER: 219-50-4778
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 44 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-29-1947
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): 2921 Edgecomb Circle North
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2921 Edgecombe Circle North
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? U S A
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Stanley W. Boswell, Sr
18. MOTHER'S NAME (First, Middle, Maiden Surname): Edith Landon
19a. INFORMANT'S NAME (Type/Print): Arnold Landon
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3026 Pineview Court N. E. Washington D. C. 20018
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery; DATE: 4392
20c. LOCATION — City or Town, State: Baltimore, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Ward
22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Avenue

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Yeast Sepsis	3 weeks
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Acquired Immunodeficiency Syndrome	5 Years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Thrombocytopenia - Probable Intracerebral Hemorrhage

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): None
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Kent, MD Robert Kent, MD
29c. LICENSE NUMBER: D06966
29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 101 W Read St Suite 211 Baltimore MD 21201
31. DATE FILED (Month, Day, Year): APR 0 6 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

N

ONMH-16 Rev 1/89

92 09388

1 · FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MIRIAM Violet Bloom
2. DATE OF DEATH (Month, Day, Year): APRIL 2, 1992
3. TIME OF DEATH: 10:28 A M
4. SOCIAL SECURITY NUMBER: 212-40-1070
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/22/16
8. BIRTHPLACE (State or Foreign Country): N.Y.
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7010 Fait Avenue
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR OATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KINO OF BUSINESS/INOUSTRY: own home
17. FATHER'S NAME (First, Middle, Last): Henry Hill
18. MOTHER'S NAME (First, Middle, Maiden Surname): Alma Salo
19a. INFORMANT'S NAME (Type/Print): Reino C. Bloom
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7010 Fait Avenue Balto, Md. 21224
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND OATE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Crematory — OATE: 4/6
20c. LOCATION — City or Town, State: Balto, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Phillip Hart M00550
22. NAME AND AODRESS OF FACILITY: Bradley Ashton Funeral Home 2134 Willow Spring Rd. Balto 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ss cerdiac or reepiratory arrest, shock, or heart feilure. List only ona cause on aech line.

		Approximate Interval Between Onset and Daath
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. ~~SEPSIS · ASPHYXIA~~ BACTEREMIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Diseass or Injury that initiated events resulting in desth) LAST	b. ~~CARDIAC ARREST~~	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.
DIABETES MELLITUS
PSEUDOMEMBRANOUS COLITIS
TOXIC MEGACOLON

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY M:
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEOICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: DAVID O. NYANISM MD
29c. LICENSE NUMBER: D 36974
29d. DATE SIGNED (Month, Day, Year): 4/2/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID O. NYANISM MD 100 N BROADWAY BALTIMORE MD 21231
31. OATE FILEO (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julie Burdon-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09389
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDNA FORD BUTTON

2. DATE OF DEATH (Month, Day, Year): 4 4 92

3. TIME OF DEATH: 8:55 PM

4. SOCIAL SECURITY NUMBER: 215-09-8392

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 83 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): MARCH 11, 1909

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: BALTIMORE

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 1310 POPLAR AVENUE

10f. ZIP CODE: 21227

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 11TH GRADE
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): GEORGE H. GROSS

18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE CHRISTINA ALHEIT

19a. INFORMANT'S NAME (Type/Print): KATHLEEN SHARON WOODY

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1310 POPLAR AVENUE-BALTIMORE, MD. 21227

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): LORRAINE PARK CEMETERY — DATE: 4/8

20c. LOCATION — City or Town, State: woodlawn

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Louis L. Smith

22. NAME AND ADDRESS OF FACILITY: HUBBARD FUN ERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Septic Shock — 4-3-92
DUE TO (OR AS A CONSEQUENCE OF):
b. metastatic Cancer colon — 4-4-92
DUE TO (OR AS A CONSEQUENCE OF):
c. Encephalitis
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Wilson James Young MD.

29c. LICENSE NUMBER: AS 24538528

29d. DATE SIGNED (Month, Day, Year): 4/4/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): St. Agnes Hospital 900 Caton Ave. Balt. MD 21229

31. DATE FILED (Month, Day, Year): APR 06 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

7

92 09390

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie Ann Cacano
2. DATE OF DEATH (Month, Day, Year): 4 4 92
3. TIME OF DEATH: 11" A M
4. SOCIAL SECURITY NUMBER: 216-03-0754
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 4, 1914
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Fallston MD.
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Harford County
10c. CITY, TOWN OR LOCATION: Forest Hill
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1706 Belvue Drive
10f. ZIP CODE: 21050
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Armando Paparelli
16. MOTHER'S NAME (First, Middle, Maiden Surname): Grace M. Papa
19a. INFORMANT'S NAME (Type/Print): Anthony B. Cacano
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1706 Belvue Drive Forest Hill, md. 21050
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Dulaney Valley Mem. Gds. — DATE: 4/8/92
20c. LOCATION — City or Town, State: Timonium, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark T. Zavoyna — ▶ Mark T. Zavoyna
22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc. 5305 Harford Rd. Balto. , Md. 21214

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Diabetes Mellitus

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Patricia E. Wright M.D.
29c. LICENSE NUMBER: D41235
29d. DATE SIGNED (Month, Day, Year): ▶ 4-4-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 200 Milton Ave. Fallston, MD 21047
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

OHMH-16 Rev 1/89

12

92 09391

1 - FOR STATE REGISTRAR YAT WAN CHEUNG

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): YAT W CHEUNG				2. DATE OF DEATH (Month, Day, Year): APRIL 3, 1992	3. TIME OF DEATH: 1:04 P M
4. SOCIAL SECURITY NUMBER: 215-76-8539	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 51 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 09/15/40	8. BIRTHPLACE (State or Foreign Country): CHINA
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: --

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1434 CLAIRIDGE ROAD		10f. ZIP CODE: 21207	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: CHINESE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last):		18. MOTHER'S NAME (First, Middle, Maiden Surname):	
19a. INFORMANT'S NAME (Type/Print): YIM MING CHEUNG (HUSBAND)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1434 CLAIRIDGE ROAD, BALTIMORE ,MD 21207	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): LORRAINE PARK CEMETERY DATE: 4/6/92	20c. LOCATION — City or Town, State: WOODLAWN,MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy M Witzke		22. NAME AND ADDRESS OF FACILITY: LEROY M & RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE CATONSVILLE,MD 21228	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	pneumonia	1 week
DUE TO (OR AS A CONSEQUENCE OF): b.	end stage liver failure	2 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Variceal bleeding, large ascites

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	26d. DESCRIBE HOW INJURY OCCURED		
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A H Gordon, M.D.	29c. LICENSE NUMBER: E9965	29d. DATE SIGNED (Month, Day, Year): 4/3/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A H GORDON, M.D. 600 N. WOLFE ST BALTO MD 21205		
31. DATE FILED (Month, Day, Year): APR 0 6 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4-205-21-80 004 A1
CHEUNG YAT

92 09392

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ARMOND JOSEPH COLLINS		2. DATE OF DEATH (Month, Day, Year): 4/4/92 (4 - 4 - 92)	3. TIME OF DEATH: 1.50 P M
4. SOCIAL SECURITY NUMBER: 218-32-6202	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): APRIL 20, 1911
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH: --	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: CATONSVILLE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 120 SMITHWOOD AVENUE	10f. ZIP CODE: 21228	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CARPENTER	16b. KIND OF BUSINESS/INDUSTRY: CONSTRUCTION/SELF EMPLOYED	
17. FATHER'S NAME (First, Middle, Last): JOSEPH COLLINS	18. MOTHER'S NAME (First, Middle, Maiden Surname): LEONA MIDDLECAMP		
19a. INFORMANT'S NAME (Type/Print): GRETCHEN COLLINS (WIFE)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 120 SMITHWOOD AVENUE CATONSVILLE MD. 21228		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ST. JOHNS CEMETERY	DATE: 4/7/92	20c. LOCATION — City or Town, State: ELLICOTT CITY MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOME 1630 EDMONDSON AVE. CATONSVILLE MD. 21228		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Aspiration pneumonia
OUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Alzheimer's dis
OUE TO (OR AS A CONSEQUENCE OF):
c.
OUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Choi, MD	29c. LICENSE NUMBER: St. Agnes	29d. DATE SIGNED (Month, Day, Year) ▶ 4/14/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
M Choi St Agnes Hosp 900 Caton Ave, Baltimore, MD

31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09393
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mazie Collins					2. DATE OF DEATH (Month / Day / Year): 4 / 1 / 92		3. TIME OF DEATH: 6:11 A M
4. SOCIAL SECURITY NUMBER: 240-20-9334	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9-18-1900		8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH		
RESIDENCE OF DECEDENT							
10a. STATE: md.	10b. COUNTY		10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO		
10e. STREET AND NUMBER: 5702 Key Ave			10f. ZIP CODE: 21215		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Worker		16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last): Samuel Collins			18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebecca Collins				
19a. INFORMANT'S NAME (Type/Print): Rebecca McDuffie			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5702 Key Ave. Balto. Md. 21215				
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland National Cem.	DATE: 4-6-92	20c. LOCATION — City or Town, State: Laurel, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Glynis B. Scott			22. NAME AND ADDRESS OF FACILITY: March Funeral Home - East 1101 E. North Ave. Balto. Md. 21202				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gangrene of Lower Extremities	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Peripheral Vascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia, Gastro Intestinal Bleed
Dementia, Malnutrition

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: [X] 1 Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Allen Rosenfeld MD		▶ 4/1/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Allen Rosenfeld MD Sinai Hospital of Baltimore, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 06 1992	Julia Davidson-Randall

DHMH-18 Rev 1/89

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CROCKER EDDIE

92 09394

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDDIE H. CROCKER
2. DATE OF DEATH (Month, Day, Year): 4 4 92
3. TIME OF DEATH: 6 01 P M
4. SOCIAL SECURITY NUMBER: 242-54-3717
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 57 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12 25 34
8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital of Baltimore
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5239 Linden Heights Ave
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 6th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Zippe Crocker
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Goode
19a. INFORMANT'S NAME (Type/Print): Vera Crocker
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5239 Linden Heights Ave. Balto. md. 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Severn Bapt. Church Cem. — DATE: 4-9-92
20c. LOCATION — City or Town, State: Severn, N.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Glynn B. Scott
22. NAME AND ADDRESS OF FACILITY: March F.H. -West 4300 Wabash Ave. Balto. md. 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. pancreatitis — DUE TO (OR AS A CONSEQUENCE OF):	
	c. Renal Failure — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AHb. Peripheral vascular dzr
h/o CVA. h/o MI h/o gout

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO — declined by family
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] (Intern)
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): ▶ 4/4/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Theodore D.K. Chung, MD PhD (Intern) Sinai Hospital @ Baltimore. 21215
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

92 09395

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): DONALD PATRICK CROGHAN			2. DATE OF DEATH MONTH 4 DAY 1 YEAR 92	3. TIME OF DEATH 800 PM M
4. SOCIAL SECURITY NUMBER: 220-20-2098	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 02-07-1927	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 3755 St. Paul Street		9b. CITY, TOWN OR LOCATION OF DEATH: Ellicott City		9c. COUNTY OF DEATH: Howard County

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard County	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3755 St. Paul Street		10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondery (0-12)	College (1-4 or 6 +): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Priest	16b. KIND OF BUSINESS/INDUSTRY: Catholic Church
17. FATNER'S NAME (First, Middle, Last): Patrick Henry Croghan		18. MOTHER'S NAME (First, Middle, Melden Surname): Josephine Irene Grzegorzewski	
19a. INFORMANT'S NAME (Type/Print): Ms. Gertrude Staiti		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3342 N. Chatham Rd.,Ellicott City,MD 21042	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND OATE OF OISPOSITION (Name of cemetary, crematory or other place): Holy Cross Cemetery DATE 4/4/92	20c. LOCATION — City or Town, State: Brooklyn Pk.,MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00535		22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home Ellicott City, Maryland 21043	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the moda of dying, such as cardiac or reapiratory arreat, ahock, or heart failure. List only ona cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic lung cancer DUE TO (OR AS A CONSEQUENCE OF):	4 wks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERREO TO MEOICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATN (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Nome 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATN: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Nomicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. OESCRIBE NOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner ee stated.
2 [ ] MEDICAL EXAMINER: On the baele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D34860	29d. DATE SIGNED (Month, Day, Year) ▶ 4-1-92

30. NAME ANO ADDRESS OF PERSON WNO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)
STEVE M. DISNER MD 3459 St. John's Ln. Ellicott City MD 21042

31. DATE FILED (Month, Day, Year): APR 0 6 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

12 N

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09396

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RICHARD W. DAWSON
2. DATE OF DEATH (Month, Day, Year): April 2, 1992
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 213-76-1671
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 32 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov. 7, 1959
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 3235 Arbor Hill Ct.
9b. CITY, TOWN OR LOCATION OF DEATH: Abingdon
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Harford
10c. CITY, TOWH OR LOCATION: Abingdon
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3235 Arbor Hill Ct.
10f. ZIP CODE: 21009
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 yr's; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Activity Instructor
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Richard B. Dawson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine R. Wilson
19a. INFORMANT'S NAME (Type/Print): Mrs. Katherine R. Dawson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3612 Evergreen Ave. Baltimore, MD 21206
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Hilltop Service DATE: 4/6/92
20c. LOCATION — City or Town, State: Towson, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock, Jr. ▶ Paul L. Hartsock, Jr.
22. NAME AND ADDRESS OF FACILITY: Baltimore, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Mycobacterium avium infection — 1 YEAR
DUE TO (OR AS A CONSEQUENCE OF):
b. RETROVIRAL INFECTION — 5 YEARS
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HISTOPLASMOSIS

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D 37168
29d. DATE SIGNED (Month, Day, Year): ▶ 4/2/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard Chasson, M.D. 1830 E. Monument Ave. Room 7401
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: [signature]

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09397
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dorothea Fern Dogge
2. DATE OF DEATH (Month, Day, Year): April 2, 1992
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 214-01-8499
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): July 17, 1908
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): 936 Dulaney Valley Road
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Towson
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 936 Dulaney Valley Road
10f. ZIP CODE: 21204
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES X
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc.: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary
16b. KIND OF BUSINESS/INDUSTRY: Shell Oil Company
17. FATHER'S NAME (First, Middle, Last): Nicholas F. Mueller
18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Roth
19a. INFORMANT'S NAME (Type/Print): Paul D. Dogge
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 936 Dulaney Valley Road Towson, Md. 21204
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Mem. April 4, 1992
20c. LOCATION — City or Town, State: Glen Burnie, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James J. Gladden
22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck Inc. 5305 Harford Road 21214

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Myocardial infarction	1/2 hr
DUE TO (OR AS A CONSEQUENCE OF): b.	Coronary atherosclerosis	years.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Advanced age	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph F. Palmisano M.D.
29c. LICENSE NUMBER: D09407
29d. DATE SIGNED (Month, Day, Year): ▶ 4-3-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph F. Palmisano MD 6608 Loch Raven Blvd. Baltimore, Maryland
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMN-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09398
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FERDINAND FRANKLIN FISSELL
2. DATE OF DEATH (Month, Day, Year): APRIL 5, 1992
3. TIME OF DEATH: 9 A M
4. SOCIAL SECURITY NUMBER: 215-07-5259
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): DEC. 31, 1914
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 118 WYNDCREST AVENUE
9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: CATONSVILLE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 118 WYNDCREST AVENUE
10f. ZIP CODE: 21228
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LINOTYPE OPERATOR
16b. KIND OF BUSINESS/INDUSTRY: PRINTING
17. FATHER'S NAME (First, Middle, Last): ROBEY FISSELL
18. MOTHER'S NAME (First, Middle, Maiden Surname): IRENE M. EMERY
19a. INFORMANT'S NAME (Type/Print): BEATRICE FISSELL (WIFE)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 118 WYNDCREST AVE. CATONSVILLE MARYLAND21228
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOWRIDGE CEMETERY — DATE: 4/8/92
20c. LOCATION — City or Town, State: DORSEY MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOME OF CATONSVILLE, 1630 EDMONDSON AVE. CATONSVILLE MARYLAND 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Ventricular Fibrillation	1 hr
DUE TO (OR AS A CONSEQUENCE OF):	ASCVD	10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):		
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D 590
29d. DATE SIGNED (Month, Day, Year): 4/5/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAYMOND BAHR M.D.
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR MARIE J. FAY

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARIE FAY			2. DATE OF DEATH (Month, Day, Year): 04 02 92	3. TIME OF DEATH: 07:30 AM
4. SOCIAL SECURITY NUMBER: 212-09-9359	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): OCT. 29, 1910	8. BIRTHPLACE (State or Foreign Country): AUSTRIA-HUNGARY
9a. FACILITY NAME (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA		9c. COUNTY OF DEATH: HOWARD

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: GERMANTOWN	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 18607 GLEN WILLOW WAY		10f. ZIP CODE: 20874	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): JOSEF MEINGER		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIA WEBER	
19a. INFORMANT'S NAME (Type/Print): STEPHEN P. PUTONEN (GRANDSON)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18607 GLEN WILLOW WAY, GERMANTOWN, MARYLAND 20874	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK LAWN CEMETERY 4/4/92	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Linda M Witzke-Lewis		22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PNEUMONIA	1 WEEK
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ISCHEMIC CARDIOMYOPATHY	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. HYPERTENSION	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. CORONARY ARTERY DISEASE	YEARS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CEREBRAL BLEED, EXPRESSIVE APHASIA, RIGHT HEMIPLEGIA, ANEMIA

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph Gittens, MD	29c. LICENSE NUMBER: D38296	29d. DATE SIGNED (Month, Day, Year): 04-02-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 9501 OLD ANNAPOLIS RD, ELLICOTT CITY, MD 21042

31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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RELEASED AS NON-MED MR BARNS PER MR GEORGE NOLE

Items: 5,6 per F.H. G-686 4/9/92 reb

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE FAULKNER

2. DATE OF DEATH (Month, Day, Year): APRIL 4,1992

3. TIME OF DEATH: 2:15a.m. M

4. SOCIAL SECURITY NUMBER: 215-80-5653

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 25 ~~24~~ YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): May 5, ~~1967~~ 1966

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY

9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: none

10c. CITY, TOWN OR LOCATION: Baltimore City

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 2847 W. Coldspringlane

10f. ZIP CODE: 21215

10g. CITIZEN OF WHAT COUNTRY? United States

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Negroid

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): 2 years

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bell Hop and Porter

16b. KIND OF BUSINESS/INDUSTRY: Hotel

17. FATHER'S NAME (First, Middle, Last): Robert Johnson

18. MOTHER'S NAME (First, Middle, Maiden Surname): Jean Faulkner

19a. INFORMANT'S NAME (Type/Print): Donzella Faulkner

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1813 Freedomway Balto, Md. 21213

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery DATE 4/8/92

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin B. Scruggs Sr.

22. NAME AND ADDRESS OF FACILITY: Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

a. Septic shock- Septic shock 1 hour — Approximate Interval Between Onset and Death: 1 hour

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Pneumonia (Pneumonia) 2 months — 2 months

DUE TO (OR AS A CONSEQUENCE OF):

c. Acquired immune deficiency syndrome (AIDS) 4 years — 4 years

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph M. Vinetz M.D.

29c. LICENSE NUMBER: JB152

29d. DATE SIGNED (Month, Day, Year): ▶ 4-4-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph M. Vinetz Johns Hopkins Hospital Baltimore, MD 21205 JHH

31. DATE FILED (Month, Day, Year): APR 06 1992

32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-18 Rev 1/69

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BETH ANN GOERTEMILLER		2. DATE OF DEATH (Month, Day, Year): April 2, 1992	3. TIME OF DEATH: 3:20 pm M
4. SOCIAL SECURITY NUMBER: 217-64-0193	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 39 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 9, 1952
8. BIRTHPLACE (State or Foreign Country): New Jersey			

9a. FACILITY NAME (If not institution, give street and number): 7809 Oakdale Ave.	9b. CITY, TOWN OR LOCATION OF DEATH: Parkville	9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3716 Bonny Bridge Place		10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4 yr's	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): EEG Technician	16b. KIND OF BUSINESS/INDUSTRY: Hospital

17. FATHER'S NAME (First, Middle, Last): Gordon R. Thompson	18. MOTHER'S NAME (First, Middle, Maiden Surname): Betty Wilhelm
19a. INFORMANT'S NAME (Type/Print): Mr. Timothy R. Goertemiller	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cem. DATE: 4/6/92	20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock, Jr. ▶ Paul L. Hartsock Jr.	22. NAME AND ADDRESS OF FACILITY: Baltimore, MD Leonard J. Ruck, Inc. 5305 Harford Rd.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hepatic Failure	1 mo.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. met. malignant melanoma to liver	1 yr.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. intraocular melanoma (uveal tract)	12/24/B
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ruth Kantor MD	29c. LICENSE NUMBER: D28594	29d. DATE SIGNED (Month, Day, Year) ▶ 4/3/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ruth Kantor, M.D. G.B.M.C. Suite 614

31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM Randolf GUE Sr.					2. DATE OF DEATH (Month / Day / Year): 04 03 1992		3. TIME OF DEATH: 7:40 A. M
4. SOCIAL SECURITY NUMBER: 213-20-3977	5. SEX: X 1 M 2 F	6. AGE (In yrs. last birthday): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 1,1926		8. BIRTHPLACE (State or Foreign Country): MAryland
9a. FACILITY NAME (If not institution, give street and number): 2820 E.MONUMENT STREET					9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT							
10a. STATE: Md.	10b. COUNTY:				10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? X 1 YES 2 NO
10e. STREET AND NUMBER: 2820 East Monument Street					10f. ZIP CODE: 21205		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 Never Married 2 X Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? X 1 YES 2 NO IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+):					16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver		16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): George Gue					18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie Mulliaux		
19a. INFORMANT'S NAME (Type/Print): Nellie Ruth Gue					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2820 E. Monument Street BAltimore Md. 21205		
20a. METHOD OF DISPOSITION: X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Cemetery	DATE: 4/6/92	20c. LOCATION — City or Town, State: BAltimore Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home					22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MAceAve. 21221		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO — INQUIRY	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA	OTHER: 4 Nursing Home X 5 Residence 6 Other (Specify)	
27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	O.C.M.E.	▶04-03-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARGARITE A, KORELL M.D. 111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 06 1992	[signature]

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09403

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frederick Edgar HARTNER Sr.
2. DATE OF DEATH (Month, Day, Year): March 31, 1992
3. TIME OF DEATH: 10:20 P.M
4. SOCIAL SECURITY NUMBER: 215-28-2083
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 60 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-17-1932
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: ROSSVILLE
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: DUNDALK
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2819 SOUTHBROOK ROAD
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: KOREA
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE — College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BUSINESS AGENT
16b. KIND OF BUSINESS/INDUSTRY: AMALGOMATED CLOTHING & TEXTILES
17. FATNER'S NAME (First, Middle, Last): EDGAR HARTNER
18. MOTNER'S NAME (First, Middle, Maiden Surname): EMMA HICK
19a. INFORMANT'S NAME (Type/Print): DOLORES E. HARTNER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2819 SOUTHBROOK ROAD BALTIMORE, MARYLAND 21222
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): CHRIST LUTHERAN CEMETERY — DATE: 4/4/92
20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ea cerdiec or reapiratory arreat, ahock, or heart feilure. List only one ceuse on eech line. — Approximete Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. Colon Cancer-Metastatic.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury that initieted events resulting in deeth) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditiona contributing to desth but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES [X] NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpetient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATN: [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be datermined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, offics building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D38776
29d. DATE SIGNED (Month, Day, Year): 3/3/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Emil Miskovsky, M.D. 9000 Franklin Square Drive., Baltimore MD. 21237.
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John P. Harper , Jr.				2. DATE OF DEATH (Month / Day / Year): 4 / 2 / 92	3. TIME OF DEATH: 3:00 A. M
4. SOCIAL SECURITY NUMBER: 215-14-0664	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov. 8,1921	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1206 Dulaney Valley Rd.			9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Balto.
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Balto.	10c. CITY, TOWN OR LOCATION: Towson			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1206 Dulaney Valley Rd.		10f. ZIP CODE: 21204		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII Army	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Contractor- John P. Harper		16b. KIND OF BUSINESS/INDUSTRY: Construction Co.	
17. FATHER'S NAME (First, Middle, Last): John P. Harper, Sr.			18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Lehneis		
19a. INFORMANT'S NAME (Type/Print): Mrs Marie C. Harper		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same As #10			
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) ENTOMBMENT		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Maus. DATE: 4-6-92		20c. LOCATION — City or Town, State: Timonium, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ronald C. Schuh		22. NAME AND ADDRESS OF FACILITY: 1050 York Rd. 21204 Ruck Towson Funeral Home, Inc.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D00359	▶ 4/2/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Aristides C. Alevizatos M.D. 301 St. Paul Place Suite 701 21202

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 0 6 1992	Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09405

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Susan F. HOLL
2. DATE OF DEATH: MONTH 04 DAY 03 YEAR 92
3. TIME OF DEATH: 2 30 PM
4. SOCIAL SECURITY NUMBER: 219-44-6149
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 46 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-21-46
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: PARKVILLE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7231 SINDALL ROAD
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12YRS. — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ADMINISTRATIVE AID
16b. KIND OF BUSINESS/INDUSTRY: MD. COURT OF APPEALS
17. FATHER'S NAME (First, Middle, Last): ALVIN F. ANDREWS
18. MOTHER'S NAME (First, Middle, Maiden Surname): SUE E. MEACHER
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MOUNT CREMATORY — DATE 4-6-92
20c. LOCATION — City or Town, State: BALTO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Paula D. Evans, D
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF CHIMES, 2325 YORK ROAD - TIMONIUM

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Breast Cancer
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. mets bone
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Carla S. Alexander MD
29c. LICENSE NUMBER: D 27087
29d. DATE SIGNED (Month, Day, Year): ▶ 04 03 92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carla S. Alexander, M.D.-Stella Maris Hospice-Dulaney Valley Rd.-Towson 21204
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR DOLORES J. HENDERSON

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dolores Henderson
2. DATE OF DEATH (Month, Day, Year): 4/4/92
3. TIME OF DEATH: 3:10 PM
4. SOCIAL SECURITY NUMBER: 218-12-2051
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): OCT. 18, 1924
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: --

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: --
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1134 COOKS LANE
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RECEPTIONIST
16b. KIND OF BUSINESS/INDUSTRY: MEDICAL
17. FATHER'S NAME (First, Middle, Last): SHANE McSHANE
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE DEMPSEY
19a. INFORMANT'S NAME (Type/Print): DONALD HENDERSON (SON)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2614 RADER AVENUE BALTIMORE MARYLAND 21234
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): NEW CATHEDRAL CEMETERY DATE: 4/8/92
20c. LOCATION — City or Town, State: BALTIMORE MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Russell Witzke
22. NAME AND ADDRESS OF FACILITY: LEROY & RUSSELL WITZKE FUNERAL HOME 1630 EDMONDSON AVE. CATONSVILLE MD. 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or reepiratory srreet, shock, or heert failure. List only one ceuse on esch line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Cerebrovascular Accident	6 days
DUE TO (OR AS A CONSEDUENCE OF):		
Sequentielly list conditions, if sny, lesding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. Atrial Fibrillation	years
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MARIAN LAMONTE, MD. LaMonte MD
29c. LICENSE NUMBER: AU41766435 AL2350
29d. DATE SIGNED (Month, Day, Year): 4/4/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARIAN LAMONTE UMMS 22 So Greene St Balto Md 21201
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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HARRIS CORDELIA
03/30/92 WHITE ESO
DIED

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09407

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S HAME (First, Middle, Last): CORDELIA HARRIS
2. DATE OF DEATH (Month, Day, Year): 4 - 4 - 92
3. TIME OF DEATH: 7:15 AM
4. SOCIAL SECURITY HUMBER: 226-58-1546
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-8-10
8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY HAME (If not institution, give street and number): SINAI HOSP., BALTIMORE
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ HO
10e. STREET AND HUMBER: 3613 OAKMONT AVENUE
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDEHT EVER IH U.S. ARMED FORCES? 1 ☐ YES 2 ☒ HO — IF YES, GIVE WAR OR DATES X
13. WAS DECEHDENT OF HISPANIC ORIGIH? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDEHT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+):
16a. DECEDEHT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S HAME (First, Middle, Last): James H. Ward
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosetta Redmond
19a. INFORMAHT'S HAME (Type/Print): Rosetta Randall
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3613 Oakmont Ave. Balto. Md. 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AHD DATE OF DISPOSITION (Name of cemetery, crematory or other place): ZION HILL Bapt. Ch. Cem. DATE 4-11-92
20c. LOCATION — City or Town, State: Gloucester, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Glynis B. Scott
22. NAME AND ADDRESS OF FACILITY: March F. H.-West 4300 Wabash Ave Balto. md. 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feiure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel diseese or condition resulting in death) →	a. RESP FAILURE	
	DUE TO (OR AS A CONSEOUEHCE OF):	
Sequentially list conditions, if any, leeding to immedieta cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST	b. Pulm Edema	
	DUE TO (OR AS A COHSEOUENCE OF):	
	c. CRF	
	DUE TO (OR AS A CONSEOUENCE OF):	
	d. PNEUMONIA	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FIHDIHGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MAHNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ HO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MWolkchem, MD
29c. LICENSE NUMBER: 961A
29d. DATE SIGNED (Month, Day, Year): ▶ 4-4-92
30. HAME AND AOORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DEPT. OF INT. MED. SINAI HOSPITAL OF BALTIMORE
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09408

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VERA HALL			2. DATE OF DEATH (Month, Day, Year): 04 02 92	3. TIME OF DEATH: 04:20 A M
4. SOCIAL SECURITY NUMBER: 212-20-9436	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS — DAYS —; IF UNDER 24 HRS.: HOURS — MIN. —)	7. DATE OF BIRTH (Month, Day, Year): 04/01/25	6. BIRTHPLACE (State or Foreign Country): OHIO
9a. FACILITY NAME (If not institution, give street and number): Fairmount Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 114 South Broadway		10f. ZIP CODE: 21231	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Clarence Hall		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel Biddle	
19a. INFORMANT'S NAME (Type/Print): Zona Boltralik	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4610 Mannasota Ave., Balto., Md. 21206		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Greenmount Cemetery — DATE:	20c. LOCATION — City or Town, State: Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Barbara L. Hall	22. NAME AND ADDRESS OF FACILITY: Lilly & Zeiler Inc. 1901 Eastern Ave. 21231		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. End Stage Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
b. —
DUE TO (OR AS A CONSEQUENCE OF):
c. —
DUE TO (OR AS A CONSEQUENCE OF):
d. —

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. —

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Sabah Al-Attar, MD	29c. LICENSE NUMBER: D37725	29d. DATE SIGNED (Month, Day, Year): ▶ 04/02/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sabah Al-Attar, MD, Church Hospital, Baltimore, MD

31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92-1849-510

92 09409

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MINNIE HOOPER					2. DATE OF DEATH: MONTH 03 DAY 31 YEAR 1992	3. TIME OF DEATH: 1:35 P M	
4. SOCIAL SECURITY NUMBER: 219-18-9129	5. SEX: 1 ☐ M 2 ☐ F XX	6. AGE (In yrs. last birthday): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 01/07/26	8. BIRTHPLACE (State or Foreign Country): Maryland	
9a. FACILITY NAME (If not institution, give street and number): 627 N. ROBINSON ST.			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH		
RESIDENCE OF DECEDENT							
10a. STATE: Md.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO		
10e. STREET AND NUMBER: 627 North Robinson Street		10f. ZIP CODE: 21205			10g. CITIZEN OF WHAT COUNTRY?: U.S.A.		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yrs. / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last): William Kress	18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna						
19a. INFORMANT'S NAME (Type/Print): John Hooper Sr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 627 N. Robinson St. Balto.,Md. 21205						
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery	DATE: 4/4	20c. LOCATION — City or Town, State: Baltimore,Md.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Anthony L. Jewell	22. NAME AND ADDRESS OF FACILITY: Lilly & Zeiler Inc. 700 S. Conkling St 21224						

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: O.C.M.E

29d. DATE SIGNED (Month, Day, Year): 03-31-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK J BERETTA 111 N. PENN ST. BALTIMORE,MARYLAND 21201

31. DATE FILED (Month, Day, Year): APR 06 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92-1829-015

92 09410

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): MICHAEL GREGORY (HANKEYCY) HANKEWYCZ
2. DATE OF OEATN — MONTH: 03 DAY: 30 YEAR: 1992
3. TIME OF DEATH: 4:40 P M
4. SOCIAL SECURITY NUMBER: 215-90-1662
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 24 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTN (Month, Day, Year): 08/15/67
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): CONRAIL RAILROAD SOUTH I-95
9b. CITY, TOWN OR LOCATION OF DEATH:
9c. COUNTY OF OEATH: CECIL

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Cecil
10c. CITY, TOWN OR LOCATION: Port Deposit
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 427 Bainbridge Road
10f. ZIP CODE: 21904
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 10 yrs. — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver
16b. KIND OF BUSINESS/INDUSTRY:
17. FATNER'S NAME (First, Middle, Last): Sofron Hankewycz
18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Andrezywski
19a. INFORMANT'S NAME (Type/Print): Sofron Hankewycz
19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 427 Bainbridge Road, Port Deposit, Md. 21904
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Michaels Ukr. Cem — DATE: 4/3
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Lilly & Zeiler Inc. 1901 Eastern Ave. 21231

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet ceused the death. Do not enter the mode of dying, such aa cardiec or respiratory erreet, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel diseese or condition resulting in death) → a. ELECTROCUTION
DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) RAILROAD TRACKS
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 03-30-1992
28b. TIME OF INJURY: ? M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. OESCRIBE HOW INJURY OCCURED: SUBJECT ELECTROCUTED
28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify): FIELD
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): CONRAIL TRAIN TRACKS, CECIL CO.
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: O.C.M.E
29d. DATE SIGNED (Month, Day, Year): 03-31-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK J. PERETTI, M 111 N. PENN ST. BALTIMORE, MARYLAND 21201
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/69

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mildred Myra Hensler

2. DATE OF DEATH (Month, Day, Year): April 3, 1992

3. TIME OF DEATH: 3:45am M

4. SOCIAL SECURITY NUMBER: 216-18-9337

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 81 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 08/15/1910

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 2 Bristol Hill Court

10f. ZIP CODE: 21228

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): Charles R. Boblitz

18. MOTHER'S NAME (First, Middle, Maiden Surname): Myra May Little

19a. INFORMANT'S NAME (Type/Print): Mr. Clifton P. Hensler,Jr

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1346 N. Rolling Rd. Balto. Md. 21228

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll United Meth Church DATE: 4/6/92

20c. LOCATION — City or Town, State: Chestnut Ridge, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Phillip Steele M0055D

22. NAME AND ADDRESS OF FACILITY: Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto. Md. 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heert feilure. Liet only one ceuse on eech line.

Approximate Interval Between Onset end Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. Sepsis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if any, leeding to immediete cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST

b. Pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

c. Cerebrovascular accident

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Mechanical ventilation

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: G. Mtanous MD H.O

29c. LICENSE NUMBER: n/a

29d. DATE SIGNED (Month, Day, Year): ▶ 4/8/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): George Mtanous, M.D. c/o Maryland General Hospital

31. DATE FILED (Month, Day, Year): APR 0 6 1992

32. REGISTRAR'S SIGNATURE: Gina Davidson-Kimble

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92 09412

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHY HAMBLIN			2. DATE OF DEATH (Month, Day, Year): 3 / 31 / 92	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 236-30-3148	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-3-1915	8. BIRTHPLACE (State or Foreign Country): WestVirginia
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4012 E. Northern Parkway		10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager	16b. KIND OF BUSINESS/INDUSTRY: Woolworth Co.	
17. FATHER'S NAME (First, Middle, Last): Winston Canady		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hallie Cooper	
19a. INFORMANT'S NAME (Type/Print): Cecil Hamblin		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4012 E. Northern Pky. Balto., Md. 21206	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Cemetery	DATE: 4/3/92	20c. LOCATION — City or Town, State: Davidsonville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lassahn Funeral Home		22. NAME AND ADDRESS OF FACILITY: Lassahn Funeral Home, Baltimore, Md. 21236	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Gram negative sepsis — days
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Urinary tract infection — days
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number; City or Town, State)

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Timothy J. Low M.D.	29c. LICENSE NUMBER: D24034	29d. DATE SIGNED (Month, Day, Year) ▶ 3/31/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Timothy J. Low MD Church Hospital		
31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: gina Davidson-Randall	

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92 09413

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BESSIE C. HECKLER			2. DATE OF DEATH (Month, Day, Year): 04 05 92	3. TIME OF DEATH: 1.:05 AM M
4. SOCIAL SECURITY NUMBER: 234-68-6561	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 04 21 11	8. BIRTHPLACE (State or Foreign Country): W.VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: PASADENA	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 194 9TH STREET		10f. ZIP CODE: 21122	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DIETARY AIDE	16b. KIND OF BUSINESS/INDUSTRY: PUBLIC HEALTH	
17. FATHER'S NAME (First, Middle, Last): JOHN LUZIER		18. MOTHER'S NAME (First, Middle, Maiden Surname): ALICE BOHAN	
19a. INFORMANT'S NAME (Type/Print): BETTY Y. GIBBS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 194 9TH STREET-PASADENA, MD. 21122	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY, INC.	DATE: 4/6	20c. LOCATION — City or Town, State: CATONSVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mary L. Kaufman	22. NAME AND ADDRESS OF FACILITY: RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY.S.W.GLEN BURNIE, MD.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	BILATERAL ASPIRATION PNEUMONIA	1/2 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	DYSPHAGIA	6 MONTHS
DUE TO (OR AS A CONSEQUENCE OF): c.	NEUROLOGIC DEGENERATIVE	2 YEARS
DUE TO (OR AS A CONSEQUENCE OF): d.	DISEASE (PARKINSON'S)	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CONTRIBUTORY ARTERY DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	N/A	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: M21851	29d. DATE SIGNED (Month, Day, Year) ▶ 4/5/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAMES T. MCCULLEN, M.D./7706 QUARTERFIELD RD./GLEN BURNIE, MD 21061		
31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall	

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09414
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna Jaroshewski			2. DATE OF DEATH (Month, Day, Year): 04/05/92	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 217-01-8757 D	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 98 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12/14/93	8. BIRTHPLACE (State or Foreign Country): Poland
9a. FACILITY NAME (If not institution, give street and number): Caton Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: City	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1312 Glyndon Avenue		10f. ZIP CODE: 21223	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ? ?	College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Unknown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown	
19a. INFORMANT'S NAME (Type/Print): Paul Jaroski		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1312 Glyndon Avenue Baltimore, MD. 21223	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Trinity R. O. Cemetery DATE: 4/9/92	20c. LOCATION — City or Town, State: Elkridge, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John J Puppel Jr		22. NAME AND ADDRESS OF FACILITY: Dippel Funeral Home, Inc. 7110 Belair Road Baltimore, MD. 21206	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive heart failure — months
DUE TO (OR AS A CONSEQUENCE OF):
b. Atrial fibrillation
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ala Stahl MD	29c. LICENSE NUMBER: D13998	29d. DATE SIGNED (Month, Day, Year): 4/6/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Stahl 4801 Dorsey Hall Drive Ellicott City, MD.

31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) EVA AMELIA JOHNSON / EVA JOHNSON			2. DATE OF DEATH MONTH DAY YEAR: 4-03-92	3. TIME OF DEATH: 11 P.M
4. SOCIAL SECURITY NUMBER: 219-12-9712	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-13-14	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): MANOR CARE NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: M.D.	10b. COUNTY: Howard County	10c. CITY, TOWN OR LOCATION: Highland		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 13249 Route 108		10f. ZIP CODE: 20777		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Associate	16b. KIND OF BUSINESS/INDUSTRY: Hecht Company		
17. FATHER'S NAME (First, Middle, Last): Rex Skipper	18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Akehurst			
19a. INFORMANT'S NAME (Type/Print): Ms. Bertha Molesworth	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9033 Old Scaggsville Rd., Laurel, MD 20723			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery 4-7-92	20c. LOCATION — City or Town, State: Highland, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00535	22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home Ellicott City, Maryland 21043			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pleural Effusion	
DUE TO (OR AS A CONSEQUENCE OF):	b. Ascites, Hepatomegaly,	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. Metastasis.	
DUE TO (OR AS A CONSEQUENCE OF):	d. Carcinoma of Ovary.	4 months

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Abdul Nayeem MD	D 21294	▶ 4/3/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ABDUL NAYEEM, M.D. 3450 FORT MEADE ROAD, LAUREL, MD. 20724

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 06 1992	Julia Davidson-Nichols

DHMH-16 Rev 1/89

(2)

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09416
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ARTEMAS W. JONES			2. DATE OF DEATH (Month, Day, Year): APRIL 3, 1992	3. TIME OF DEATH: 11:15 P. M
4. SOCIAL SECURITY NUMBER: 233-14-4505	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): APRIL 19, 1907	8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): 1926 HARMAN AVENUE		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1926 HARMAN AVENUE		10f. ZIP CODE: 21230		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 3 YRS	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRINTER		16b. KIND OF BUSINESS/INDUSTRY: McCORMICK SPICE CO.
17. FATHER'S NAME (First, Middle, Last): WALTER H. JONES		18. MOTHER'S NAME (First, Middle, Maiden Surname): FLORENCE R. BATTEN		
19a. INFORMANT'S NAME (Type/Print): CLARICE JONES		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1926 HARMAN AVENUE - BALTIMORE, MD. 21230		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): LAKEVIEW MEMORIAL PARK	DATE: 4/7	20c. LOCATION — City or Town, State: SYKESVILLE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M. Neal Coleman		22. NAME AND ADDRESS OF FACILITY: HOWARD H.HUBBARD FUNERAL HOME, INC. 4107 Wilkens Ave, Baltimore, MD 21229		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic malignant melanoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D20040	29d. DATE SIGNED (Month, Day, Year): 4/6/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. JAMES EVANS - 700 WASHINGTON BOULEVARD - BALTIMORE, MARYLAND 21230

31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

12

92 09417

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERIC WAYNE KROB		2. DATE OF DEATH (Month, Day, Year): MARCH 31, 1992	3. TIME OF DEATH: 12:22 P M
4. SOCIAL SECURITY NUMBER: 223-17-2113	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 30 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 14, 1961
8. BIRTHPLACE (State or Foreign Country): Texas			
9a. FACILITY NAME (If not institution, give street and number): MALCOLM GROW USAF MEDICAL CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: ANDREWS AFB, MD	9c. COUNTY OF DEATH: PRINCE GEORGES	
RESIDENCE OF DECEDENT			
10a. STATE: Virginia	10b. COUNTY: Fairfax	10c. CITY, TOWN OR LOCATION: Falls Church	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3100 S. Manchester Street	10f. ZIP CODE: 22044	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Technician	16b. KIND OF BUSINESS/INDUSTRY: Computer Maintainace	
17. FATHER'S NAME (First, Middle, Last): Larry Dean Krob	18. MOTHER'S NAME (First, Middle, Maiden Surname): Sharon Scherman		
19a. INFORMANT'S NAME (Type/Print): Sharon Powers	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2004 Rawood Drive, Hampton, Virginia 23663		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory	20c. LOCATION — City or Town, State: Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Melvin C. Powell	22. NAME AND ADDRESS OF FACILITY: Colonial Funeral Home 6161 Leesburg Pike, Falls Church, Va. 22044		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. HEMOPTYSIS	2 DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ACQUIRED IMMUNODEFICIENCY SYNDROME	5 YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
E. Ronald Hale MD		▶MARCH 31, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. RONALD HALE, CAPTAIN, USAF, MC — MALCOLM GROW USAF MEDICAL CENTER, ANDREWS AFB, MD 20331-5300

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 06 1992	Gina Davidson-Randall

OHMH-16 Rev 1/89

92 09418

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH GEORGE LeFROIS			2. DATE OF DEATH (Month, Day, Year): April 2,1992	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 227-64-7161	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept.14,1917	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): 911 W. Lake Ave.		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10e. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore City		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 911 W. Lake Ave.		10f. ZIP CODE: 21210		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Catholic Priest		16b. KIND OF BUSINESS/INDUSTRY: Church
17. FATHER'S NAME (First, Middle, Last): George LeFrois		18. MOTHER'S NAME (First, Middle, Maiden Surname): Vera Smith		
19a. INFORMANT'S NAME (Type/Print): St. Joseph Society of the Sacred Heart		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1130 N. Calvert St. Baltimore,MD 21202		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Immaculate Conception	DATE: 4/9/92	20c. LOCATION — City or Town, State: Lebeau,La.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock,Jr. ▶ Paul L. Hartsock, Jr.		22. NAME AND ADDRESS OF FACILITY: Baltimore,MD 21214 Leonard J. Ruck,Inc. 5305 Harford Rd.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D16086	29d. DATE SIGNED (Month, Day, Year) ▶ 4/3/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): George LaRocco,M.D. O'Dea Medical Building Suite 502		
31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/69

92 09419

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JACK L. LIGHT			2. DATE OF DEATH (Month, Day, Year): APRIL 3, 1992	3. TIME OF DEATH: 5" A M
4. SOCIAL SECURITY NUMBER: 234-22-6309	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 29, 1923	8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): 3421 ORLANDO AVE.		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3421 ORLANDO AVE.		10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: W.W.II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BASS RANGER	16b. KIND OF BUSINESS/INDUSTRY: M.T.A.

17. FATHER'S NAME (First, Middle, Last): ROY W. LIGHT	18. MOTHER'S NAME (First, Middle, Maiden Surname): VERNIE A. ANDERSON
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEMETERY	DATE: 4-6-92	20c. LOCATION — City or Town, State: PARKVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8500 HARFORD ROAD - PARKVILLE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CVS intestrum	1 Mo
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Non Small Cell Ca of Lung	6 Mo
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D10091	29d. DATE SIGNED (Month, Day, Year): APRIL 3, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. ARTHUR A. SERPICK 7620 YORK ROAD - TOWSON

31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Paul Robert Loughran
2. DATE OF DEATH (Month, Day, Year): April 3, 1992
3. TIME OF DEATH: 2:15 PM
4. SOCIAL SECURITY NUMBER: 216-20-8086
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 66 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01/12/26
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): 6718 Richardson Road
9b. CITY, TOWN OR LOCATION OF DEATH: Woodlawn
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Woodlawn
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 6718 Richardson Road
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Trouble Analyzer
16b. KIND OF BUSINESS/INDUSTRY: C&P Telephone Co
17. FATHER'S NAME (First, Middle, Last): Paul H. Loghran
18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Pikey
19a. INFORMANT'S NAME (Type/Print): Dorothy M. Loughran
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6718 Richardson Road Woodlawn, Md. 21207
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans
DATE: 4/7
20c. LOCATION — City or Town, State: Owings Mills, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert A Modarelli mo0933
22. NAME AND ADDRESS OF FACILITY: Sterling Ashton Funeral Home, Inc. 736 Edmondson Avenue 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Diabetes Mellitus.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.
History of Anemia
Diabetic Neuropathy

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: R. [illegible]
29c. LICENSE NUMBER: D31726
29d. DATE SIGNED (Month, Day, Year): ▶ 4/6/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Raafat Y. Girgis
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09421

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MEI KING LEE (Mei King Tam Lee)

2. DATE OF DEATH Month: 3 Day: 28 Year: 92

3. TIME OF DEATH: 2:38 M

4. SOCIAL SECURITY NUMBER: 577-72-8210

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 65 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Sept. 18, 1926

8. BIRTHPLACE (State or Foreign Country): China

9a. FACILITY NAME (If not institution, give street and number): 11722-Georgia Avenue

9b. CITY, TOWN OR LOCATION OF DEATH: Wheaton

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Wheaton

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 11722-Georgia Avenue

10f. ZIP CODE: 20902

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Oriental

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker

15b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): Pui Tam

15. MOTHER'S NAME (First, Middle, Maiden Surname): Shee Wong

19a. INFORMANT'S NAME (Type/Print): Wah H. Lee (Son)

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13508-Stock Bridge Court, Silver Spring, MD 20906

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Washington National Cemetery

20c. LOCATION — City or Town, State: Suitland, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles L. Bélanger

22. NAME AND ADDRESS OF FACILITY: J.William Lee's Sons Company Funeral Home
300-4th Street, NE, Washington, DC 20002

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Carcinoma of the Breast
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Non insulin dependent Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

25f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: D27865

29d. DATE SIGNED (Month, Day, Year): ▶ 3/28/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARK K LI M.D. 1721 University Blvd W. Wheaton MD 20902

31. DATE FILED (Month, Day, Year): APR 06 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09422 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MACK LEWIS
2. DATE OF DEATH (Month, Day, Year): 3 - 31 - 92
3. TIME OF DEATH: 2:31 P M
4. SOCIAL SECURITY NUMBER: 217-01-7390
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 97 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7-9-18[illegible]
8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: —

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: —
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2040 E. Lanvale St.
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Crane Operator
16b. KIND OF BUSINESS/INDUSTRY: Steel Co.
17. FATHER'S NAME (First, Middle, Last): Andrew Lewis
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Bagley
19a. INFORMANT'S NAME (Type/Print): Corine Fleming
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2040 E. Lanvale St. Balto. Md. 21213
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Md. Nat. Mem. Park — DATE: 4-92
20c. LOCATION — City or Town, State: Laurel, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph J. Collick
22. NAME AND ADDRESS OF FACILITY: Collick F.H. 21213 — 2431 E. Oliver St. Balto. Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ee cerdiac or reepiratory errest, shock, or hesrt feilure. List only one cauee on esch line.

Approximets Interval Between Onset end Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration Pneumonia — 31 min
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. RL Pneumonia — 7 days
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Prostatic CA c mets to bones
Chronic Renal Insufficiency

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 [ ] MEDICAL EXAMINER: On the baele of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(e) end menner es stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Antonio A. Pedro M.D.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 3-31-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5601 Loch Raven Blvd. Balto, M.D. 21239 ANTONIO A. PEDRO
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-18 Rev 1/89

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92 09423

Issued via
Court Order
92 CV 1531
Judge John F. Fader,

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last): Thomas H. Edwin Mitchell

2. DATE OF DEATH Month: 1 Day: 14 Year: 92 — Court ordered

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 218-62-1671

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 39 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 4/7/52

8. BIRTHPLACE (State or Foreign Country): MD

9a. FACILITY NAME (If not institution, give street and number): nr.Bodkin Island in Eastern Bay

9b. CITY, TOWN OR LOCATION OF DEATH:

9c. COUNTY OF DEATH: Queen Anne's

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: ----------

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 1118 Newfield Road

10f. ZIP CODE: 21207

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] ND Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer - Marine

16b. KIND OF BUSINESS/INDUSTRY: Shipping

17. FATHER'S NAME (First, Middle, Last): Donald C. Mitchell

18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Janet Gamber

19a. INFORMANT'S NAME (Type/Print): Julia K. Mitchell

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1118 Newfield Road Baltimore, MD 21207

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) none

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) — DATE:

20c. LOCATION — City or Town, State:

21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶

22. NAME AND ADDRESS DF FACILITY:

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the daeth. Do not enter the mode of dying, such ss cardiec or respiratory arrest, shock, or hasrt failure. List only ona cause on asch line.

Approximata Interval Between Onset snd Death

IMMEDIATE CAUSE (Finsl disease or condition resulting in daath) →
a. DROWNING
DUE TO (DR AS A CONSEDUENCE DF):

Sequentislly list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEDUENCE OF):
c.
DUE TO (DR AS A CONSEDUENCE OF):
d.

PART II. Other significent conditions contributing to desth but not resulting in tha underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 [ ] YES 2 [ ] ND

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) water

27. MANNER DF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 1/14/92

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO

28d. DESCRIBE HOW INJURY OCCURED: boat capsized

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): water

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): off Bodkin Is. in Eastern Bay

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John E. Smialek, M.D.

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year) ▶ Court Ordered

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John E. Smialek, M.D. - Chief 111 Penn St. Balto.MD 21201

31. DATE FILED (Month, Day, Year): APR 3 1992

32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

OHMH-16 Rev 1/89

92 09424

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): JEROME JOSEPH MEMMEL

2. DATE OF DEATH — MONTH: 04 DAY: 01 YEAR: 92

3. TIME OF DEATH: 3 10 PM

4. SOCIAL SECURITY NUMBER: 214-16-8568

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 4-10-21

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: BALTIMORE CITY

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 500 WEST FRANKLIN STREET

10f. ZIP CODE: 21201

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES [X] NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEOENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 10 YEARS — College (1-4 or 5+): N/A

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RADIO TECHNICIAN

16b. KIND OF BUSINESS/INDUSTRY: BENDIX

17. FATHER'S NAME (First, Middle, Last): MICHAEL ANTHONY MEMMEL

18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA H. DWYER

19a. INFORMANT'S NAME (Type/Print): EILEEN E. MEYERS

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1946 HOLBORN ROAD BALTIMORE, MARYLAND 21222

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY REDEEMER CEMETERY — DATE: 4/4/92

20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Chas W. Fisher

22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC RENAL FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. METASTATIC CARCINOMA of PROSTRATE

DUE TO (OR AS A CONSEQUENCE OF):

c. ARTERIOSCLEROTIC HEART DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MYELOPROLIFERATIVE DISORDER
URINARY TRACT INFECTION
ANAEMIA

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S.D. Patel M.D.

29c. LICENSE NUMBER: D 23300

29d. DATE SIGNED (Month, Day, Year): 04-01-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SUDHIR D. PATEL. Liberty Medical Center 2600 Liberty Rd. Balto MD. 21215

31. DATE FILED (Month, Day, Year): APR 0 6 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09425

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John M. Martini (John M. Martini)
2. DATE OF DEATH: MONTH 4 DAY 3 YEAR 92
3. TIME OF DEATH: 5 P.M
4. SOCIAL SECURITY NUMBER: 220 09 9592
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 88 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8 17 03
8. BIRTHPLACE (State or Foreign Country): Minnesota
9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice
9b. CITY, TOWN OR LOCATION OF DEATH: Towson Md
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Parkville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7818 Bagley Avenue
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 8
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): School Teacher - Ret.
16b. KIND OF BUSINESS/INDUSTRY: Baltimore City
17. FATHER'S NAME (First, Middle, Last): John Martini
18. MOTHER'S NAME (First, Middle, Maiden Surname): Alicia Dunn
19a. INFORMANT'S NAME (Type/Print): M. Robert Martini
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18 Kimball Ridge Court Baltimore, Md. 21228
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Bel Air Memorial 4/7/92 — DATE
20c. LOCATION — City or Town, State: Bel Air Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Milton J. Knight Jr — Milton J. Knight Jr
22. NAME AND ADDRESS OF FACILITY: Baltimore, Md. 21214 — Leonard J. Ruck, Inc. 5305 Harford Road

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c. Cardio vascular disease
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Cancer Prostate

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: DR Eddie Markuda
29c. LICENSE NUMBER: 16504
29d. DATE SIGNED (Month, Day, Year): 4/3/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR Eddie Markuda Stella Maris Hospice
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Gina Davidson-Kendall

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

92 09426

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leroy Mason, Sr	2. DATE OF DEATH (Month / Day / Year): 4 / 3 / 92	3. TIME OF DEATH: 6AM M	
4. SOCIAL SECURITY NUMBER: 239-14-6649	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12/25/11
8. BIRTHPLACE (State or Foreign Country): Va			
9a. FACILITY NAME (If not institution, give street and number): 316 Millington Ave	9b. CITY, TOWN OR LOCATION OF DEATH: Balto	9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 316 Millington Ave	10f. ZIP CODE: 21223	10g. CITIZEN OF WHAT COUNTRY? U.S.A	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4th; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Sollie Mason	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Mason
19a. INFORMANT'S NAME (Type/Print): Teresa A. Mason	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 316 Millington Ave Balto, md 21223

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Townsville Cem DATE 4-7-92	20c. LOCATION — City or Town, State: Crownsville, md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Portia Elbron	22. NAME AND ADDRESS OF FACILITY: March F. Hurst 4300 Wabash Ave	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cancer of Prostate DUE TO (OR AS A CONSEQUENCE OF):	6 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 4/3/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Mahamed Al-Thriham HBHC-BVAMC 3900 Loch Raven Blvd 21218

31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

IV 4-1

92 09427

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MAXINE MAYES
2. DATE OF DEATH: MONTH 4 DAY 2 YEAR 92
3. TIME OF DEATH: 12:53A M
4. SOCIAL SECURITY NUMBER: 217-24-0890
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 63 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-01-1929
8. BIRTHPLACE (State or Foreign Country): BALTIMORE, MD.
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3620 REISTERSTOWN ROAD
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DIRECTOR OF RECREATION
16b. KIND OF BUSINESS/INDUSTRY: BALTIMORE CITY
17. FATHER'S NAME (First, Middle, Last): SPICER LAWS
18. MOTHER'S NAME (First, Middle, Maiden Surname): SADIE FOSTER
19a. INFORMANT'S NAME (Type/Print): EVELYN LAWS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3620 REISTERSTOWN ROAD, BALTIMORE, MD. 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other piece): ARBUTUS CEMETERY DATE:
20c. LOCATION — City or Town, State: ARBUTUS, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald D. Brown
22. NAME AND ADDRESS OF FACILITY: JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST. BALTO. MD. 21223; P.O. BOX 4433

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac arrythmias	20 min
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Pulmonary edema	15 hours
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Myocardial infarction	15 hours
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D40491
29d. DATE SIGNED (Month, Day, Year): 4/2/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SYED M A RIAZ MD 2600 Liberty Hgts Balto MD 21215
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

IF HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
IF FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

92 09428

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gertrude Malone
2. DATE OF DEATH (Month, Day, Year): 4 3 92
3. TIME OF DEATH: 7 AM PM
4. SOCIAL SECURITY NUMBER: 219-01-1198
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday) YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb 4 1894
8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number): 5313 Barbara ave
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore 21214
9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY
10c. CITY, TOWN OR LOCATION: Baltimore MD
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 5313 Barbara ave
10f. ZIP CODE: Baltimore 21214
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify:
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: None
17. FATHER'S NAME (First, Middle, Last): Clayton Bertram
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary
19a. INFORMANT'S NAME (Type/Print): Ella Mae Edmonds
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1716 E Belvedere ave 21239
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington Memorial — DATE: 4892
20c. LOCATION — City or Town, State: Baltimore MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Willis Williams
22. NAME AND ADDRESS OF FACILITY: 2302 W North ave Baltimore MD 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Coronary artery disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Atrial Fibrillation

DUE TO (OR AS A CONSEQUENCE OF):

c. Dementia

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Attending Physician
29c. LICENSE NUMBER: D30115
29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): T. Ohiokpehai, MD 2600 Liberty Heights Ave #1186 Balt., MD 21215

31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

3.

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09429

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Emil G Reitz Jr.
2. DATE OF DEATH: MONTH 4 DAY 3 YEAR 92
3. TIME OF DEATH: 3 A M
4. SOCIAL SECURITY NUMBER: 212-05-2364
5. SEX: 1 [X] M 2 [ ] F
6. AGE (in yrs. last birthday): 82 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-18-10
8. BIRTHPLACE (State or Foreign Country): Frederick Md.
9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: Glen ARM
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 13209 MANOR ROAD
10f. ZIP CODE: 21057
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W.W. II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12YRS. College (1-4 or 5+): 4 YRS.
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ATHLETIC DIRECTOR
16b. KIND OF BUSINESS/INDUSTRY: Loyola College
17. FATHER'S NAME (First, Middle, Last): EMIL G. REITZ, SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZA SHIPLEY
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): E.M. ST. JOHN'S CHURCH — DATE 4-7-92
20c. LOCATION — City or Town, State: Long Green, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paula E. Evans, Jr.
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF CHIMES 2325 York Road - Timonium

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colon Cancer
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastatic disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Carla A. Alexander MD
29c. LICENSE NUMBER: D 27087
29d. DATE SIGNED (Month, Day, Year): 4-3-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carla S. Alexander, M.D.-Stella Maris Hospice-Dulaney Valley Rd.-Towson 21204
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09430

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUBIN RIDER
2. DATE OF DEATH (Month, Day, Year): 4-6-92
3. TIME OF DEATH: 723A M
4. SOCIAL SECURITY NUMBER: 086-36-7214
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 10 17 1917
8. BIRTHPLACE (State or Foreign Country): Poland
9a. FACILITY NAME (If not institution, give street and number): Baltimore County Gen'l. Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown, MD
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6901 Alter Street
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Butcher
16b. KIND OF BUSINESS/INDUSTRY: Food
17. FATHER'S NAME (First, Middle, Last): Ephraim Rider
18. MOTHER'S NAME (First, Middle, Maiden Surname): Miriam Ackerstein
19a. INFORMANT'S NAME (Type/Print): Henry Rider
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2707 Moores Valley Dr. Balt. MD 21209
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Beth Jacob Cemetery — DATE: 4/7
20c. LOCATION — City or Town, State: Finksburg, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael P. Marzullo pns
22. NAME AND ADDRESS OF FACILITY: Hebrew Memorial Funeral Home, Inc. 1100 Reisterstown Rd. Balt. MD 21208

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused tha death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert feiiure. List only one ceuse on each line.

Approximate Interval Between Onset end Deeth

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebro Vascular accident
OUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. Right middle cerebral artery occlusion
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Myocardial Infarction
Permanent Pacemaker
Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D27157
29d. DATE SIGNED (Month, Day, Year): ▶ 4-6-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAYNOLD DEFESTRE BALTIMORE COUNTY GENERAL HOSPITAL
31. DATE FILED (Month, Day, Year): APR 0 6 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09431
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lottie G. Riggsbee			2. DATE OF DEATH (Month, Day, Year): April 1, 1992	3. TIME OF DEATH: 4:11am M
4. SOCIAL SECURITY NUMBER: 217-24-6623	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-10-10	8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATN
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore, City		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5763 Hazelwood Circle		10f. ZIP CODE: 21206		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Hemphill		18. MOTNER'S NAME (First, Middle, Maiden Surname): Bertha		
19a. INFORMANT'S NAME (Type/Print): Alexander Riggsbee		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5763 Hazelwood Cir/ Baltimore, Md. 21206		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery	DATE	20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bernard D Johnson		22. NAME AND ADDRESS OF FACILITY: Wm.C. March F/H 1101 E.North Ave.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive heart failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertension	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF OEATH (Check only one): HOSPITAL: ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Christopher Ciliberto M.D.	29c. LICENSE NUMBER: n/a	29d. DATE SIGNED (Month, Day, Year): ▶ 04/01/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Christopher Ciliberto, M.D. c/o Maryland General Hospital		
31. DATE FILED (Month, Day, Year): APR 0 6 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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92 09432

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY (NMI) RALEIGH			2. DATE OF DEATH (Month, Day, Year): 4 4 92	3. TIME OF DEATH: 12 45 PM
4. SOCIAL SECURITY NUMBER: 118-09-3639	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): FEB 06 1907
8. BIRTHPLACE (State or Foreign Country): IRELAND				
9a. FACILITY NAME (If not institution, give street and number): JENKINS MEMORIAL HOME		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: HARFORD	10c. CITY, TOWN OR LOCATION: BELCAMP		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1241 CALDWELL COURT		10f. ZIP CODE: 21017		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SEAMSTRESS		16b. KIND OF BUSINESS/INDUSTRY: CLOTHING MANUFACTURING
17. FATHER'S NAME (First, Middle, Last): Daniel MURPHY		18. MOTHER'S NAME (First, Middle, Maiden Surname): Kathleen HORRIGAN		
19a. INFORMANT'S NAME (Type/Print): Daniel P. RALEIGH		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1241 CALDWELL CT, BELCAMP, MD 21017		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY		20c. LOCATION — City or Town, State: WESTCHESTER, NY
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dawn E. Smith		22. NAME AND ADDRESS OF FACILITY: HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE, BALTIMORE, MD 21229		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CEREBROVASCULAR ACCIDENT	1 WK
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	HTN	>10 YRS
DUE TO (OR AS A CONSEQUENCE OF):		
c.	MULTIINFARCTION DEMENTIA	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
William Russell MD	D 30182	▶ 5/5/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM RUSSELL, MD 3320 BENSON AVE BALT MD 21227

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 06 1992	Irma Davidson-Randall

DHMH-16 Rev 1/89

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92 09433

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOLORES L. SAMPSON		2. DATE OF DEATH (Month / Day / Year): 4 / 5 / 92	3. TIME OF DEATH: 7:20 AM
4. SOCIAL SECURITY NUMBER: 218-18-1796	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): MARCH 18, 1912	8. BIRTHPLACE (State or Foreign Country): MARYLAND		
8a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: LARNEY	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8903 WALTHAM WOODS ROAD	10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 YRS. / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BOOKKEEPER	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): GEORGE L. LOYD	18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY A. MURPHY		
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): NEW LATHIORAL	DATE: 4-8-92	20c. LOCATION — City or Town, State: BALTO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael D. Aresse, MD	29c. LICENSE NUMBER: D40547	29d. DATE SIGNED (Month, Day, Year): ▶ 4/5/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL D. ARESSE, M.D., ST. JOSEPH HOSPITAL, INC., 7620 YORK RD., TOWSON, MD 21204

31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09434

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNA C. SIEGERT			2. DATE OF DEATH (Month, Day, Year): APRIL 3, 1992	3. TIME OF DEATH: 1:20 AM
4. SOCIAL SECURITY NUMBER: 215-22-0287	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): MARCH 15, 1913	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 1907 NORHURST WAY NORTH		9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: CATONSVILLE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1907 NORHURST WAY NORTH		10f. ZIP CODE: 21228	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): JOHN W. STEMBLER		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH E. O'NEILL	
19a. INFORMANT'S NAME (Type/Print): BARBARA JANOWIAK (DAUGHTER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1907 NORHURST WAY NORTH, CATONSVILLE, MD. 21228	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL PARK	DATE: 4/6/92	20c. LOCATION — City or Town, State: DORSEY, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Russell Witzke		22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Liver Failure	3 days
DUE TO (OR AS A CONSEQUENCE OF):	b. Metastatic liver disease	4 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. Carcinoma of colon	4 years
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Narayan	29c. LICENSE NUMBER: D26381	29d. DATE SIGNED (Month, Day, Year): 4/3/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): VIJAY NARAYEN M.D. 3455 WILKENS AVENUE, BALTIMORE, MARYLAND 21229

31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM E SHAMBLEY			2. DATE OF DEATH (Month, Day, Year): APRIL 5, 1992	3. TIME OF DEATH: 7:44 a.m M
4. SOCIAL SECURITY NUMBER: 241-76-9795	5. SEX: 1 [X] M 2 [ ] F	8. AGE (In yrs. last birthday): 43 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9-27-48	6. BIRTHPLACE (State or Foreign Country): N.C
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore, City	10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 825 N. Chapel Street		10f. ZIP CODE: 21205	10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled	16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): James H. Shambley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lee Edna Drake	
19a. INFORMANT'S NAME (Type/Print): Richardson Funeral Home		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 607 S. Main St./ Louisburg, N.C. 27549	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, crematory or other place): Shambley Family Plot	DATE	20c. LOCATION — City or Town, State: Nashville, N.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Wm.C. March F/H 1101 E. North Ave.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumocystis Pneumonia	1 mo
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Acquired Immunodeficiency Syndrome	5 years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: Pulmonary

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year) ▶ 4/05/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHNS HOPKINS HOSPITAL, BRIAN HOUGH, M.D.		
31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Smith (William H. Smith)
2. DATE OF DEATH (Month, Day, Year): 4/2/92
3. TIME OF DEATH: 408P M
4. SOCIAL SECURITY NUMBER: 226-12-6278
5. SEX: 1 XX M 2 ☐ F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-29-14
8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): University Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore, City
10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 900 Kenwood Avenue
10f. ZIP CODE: 21205
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO XX Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 3rd — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY: Monarch Rubber Co.
17. FATHER'S NAME (First, Middle, Last): Henry Smith
16. MOTHER'S NAME (First, Middle, Maiden Surname): Ela Gay Williams
19a. INFORMANT'S NAME (Type/Print): Shirley Johnson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 900 N. Kenwood Ave./ Baltimore, Md. 21205
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery — DATE
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Conard Gallier
22. NAME AND ADDRESS OF FACILITY: Wm.C. March F/H 1101 E. North Ave.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complicetione that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory srrest, shock, or heert failure. List only ona ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebral Hemiation — 4 days
DUE TO (OR AS A CONSEQUENCE OF):
b. Right internal carotid infarction
DUE TO (OR AS A CONSEQUENCE OF):
c. MASSIVE pituitary hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):
d. Pituitary adenoma — X

Sequentially list conditions, if any, leading to immedieta cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significent conditione contributing to deeth but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to tha cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): ▶ 4/2/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Arthur DiPatri U. Md Md System — 22 S. Greene Street Balt MD 21201
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/99

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Donald Scott			2. DATE OF DEATH (Month, Day, Year): 04 02 1992	3. TIME OF DEATH: 6:50 A M
4. SOCIAL SECURITY NUMBER: 219-40-8109	5. SEX: 1 [X] M 2 [ ] F	8. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-15-1939	8. BIRTHPLACE (State or Foreign Country): BALTIMORE, MD.
9a. FACILITY NAME (If not institution, give street and number): 226 N. Carlton Avenue		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2705 CARVER ROAD		10f. ZIP CODE: 21225		10g. CITIZEN OF WHAT COUNTRY? USA.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): COOK		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): CLARENCE UPSHIRE		18. MOTHER'S NAME (First, Middle, Maiden Surname): BERNICE SCOTT		
19a. INFORMANT'S NAME (Type/Print): CHERYL PARKER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5930 HILLEN ROAD, BALTIMORE, MD. 21239		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MT. ZION CEMETERY — DATE:		20c. LOCATION — City or Town, State: BALTIMORE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles D. Br		22. NAME AND ADDRESS OF FACILITY: JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST. BALTO. MD. 21223; P.O. BOX 4433		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or hesrt feilure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Aaron Locke MD	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ 04 02 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AARON LOCKE, MD 111 Penn Street, Baltimore Maryland 21201		
31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Hendricks	

DHMH-16 Rev 1/89

92 09438

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Roberta Lee SEBREE			2. DATE OF DEATH (Month, Day, Year): April 2, 1992	3. TIME OF DEATH: 4:31PM M
4. SOCIAL SECURITY NUMBER: 215-18-5076A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-13-1921	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Rossville		9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4518 Raspe Avenue		10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesperson	16b. KIND OF BUSINESS/INDUSTRY: Woolworth's	
17. FATHER'S NAME (First, Middle, Last): Oliver R. Casey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances S. Esley	
19a. INFORMANT'S NAME (Type/Print): John Sebree, Sr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4518 Raspe Avenue Baltimore, Md. 21206		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery	DATE: 4/6/92	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lassahn Funeral Home	22. NAME AND ADDRESS OF FACILITY: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Asystole; Acute MI	immed
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stuart B. Bell MD	29c. LICENSE NUMBER: D22789	29d. DATE SIGNED (Month, Day, Year) ▶ 4/3/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Stuart B. Bell, M. D.	3501 St. Paul St. -21218	
31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

DHMH-18 Rev 1/89

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92 09439

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ESTHER I. SCHWATKA
2. DATE OF DEATH (Month, Day, Year): 04 04 92
3. TIME OF DEATH: 03:12 AM M
4. SOCIAL SECURITY NUMBER: 214-16-8800
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 87 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 07 26 04
8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL ASSOCIATION
9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE
9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: ANNE ARUNDEL
10c. CITY, TOWN OR LOCATION: PASADENA
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 42 BROOKFIELD ROAD
10f. ZIP CODE: 21122
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK
16b. KIND OF BUSINESS/INDUSTRY: DRY GOOD'S SALES
17. FATHER'S NAME (First, Middle, Last): HENRY LUTZ
18. MOTNER'S NAME (First, Middle, Maiden Surname): KATE SWEIGART
19a. INFORMANT'S NAME (Type/Print): PHYLLIS M. RIDGEWAY
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 42 BROOKFIELD ROAD-PASADENA, MD. 21122
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ [illegible] 4 ☐ Donation 5 ☐ Other (Specify): ENTOMBMENT
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): CEDAR HILL CEMETERY — DATE: 4/7
20c. LOCATION — City or Town, State: BROOKLYN PARK, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L. Kaufmann
22. NAME AND ADDRESS OF FACILITY: RAYMOND C. FINK FUNERAL HOME 21061, 426 CRAIN HWY.S.W.GLEN BURNIE, MD.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that ceused tha death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, shock, or heert failure. Liat only one cause on each line.

Approximata Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Cardio pulmonary arresti
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Congestive Heart Feilure
DUE TO (OR AS A CONSEOUENCE OF):
c. Rx Interstitual Lung disecese
DUE TO (OR AS A CONSEOUENCE OF):
d.

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO — N/A
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: A. manjuela
29c. LICENSE NUMBER: D29748
29d. DATE SIGNED (Month, Day, Year): ▶ 4/4/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALIF M. MANEJWALA, M.D./1307 CRAIN HWY S.E./GLEN BURNIE, MARYLAND 21061
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92 09440

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANK B. TONDRICK
2. DATE OF DEATH: MONTH 3 DAY 31 YEAR 92
3. TIME OF DEATH: 6 20 P M
4. SOCIAL SECURITY NUMBER: 165-20-6912
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): MAY 13, 1927
8. BIRTHPLACE (State or Foreign Country): PENN.
9a. FACILITY NAME (If not institution, give street and number): GOOD SAMARITAN HOSP.
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: —

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE CO.
10c. CITY, TOWN OR LOCATION: PARKVILLE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10a. STREET AND NUMBER: 1915 HAVERHILL ROAD
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: KOREAN WAR
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — ~~American Indian~~, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 6
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SCHOOL PRINCIPAL
16b. KIND OF BUSINESS/INDUSTRY: BALTO. CO. SCHOOLS
17. FATHER'S NAME (First, Middle, Last): WALTER TONDRICK
18. MOTHER'S NAME (First, Middle, Maiden Surname): PAULINE AZAREWICZ
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): BUCHART VALLEY MEM. DATE 4-4
20c. LOCATION — City or Town, State: COCKEYSVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Gair
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 5800 HARFORD RD. 21234

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. V. Tachycardia or V. fibrillation — min.
DUE TO (OR AS A CONSEQUENCE OF):
b. ACUTE MYOCARDIAL INFARCTION — min.
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
c. ARTERIOSCLEROTIC CORONARY ART. DISEASE — YEARS
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: K. F. Awalt M.D.
29c. LICENSE NUMBER: D00391
29d. DATE SIGNED (Month, Day, Year): 4/2/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. LAWRENCE AWALT 120 SISTER PIERRE DRIVE
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR A.K.A. CATHERINE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): KATHERINE E. THOMPSON			2. DATE OF DEATH (Month, Day, Year): 4-2-92	3. TIME OF DEATH: 935 AM
4. SOCIAL SECURITY NUMBER: 020-20-3296	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12/27/10	8. BIRTHPLACE (State or Foreign Country): MASSACHUSETTS
9a. FACILITY NAME (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA		9c. COUNTY OF DEATH: HOWARD

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: HOWARD	10c. CITY, TOWN OR LOCATION: COLUMBIA	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 10810 GREEN VIEW WAY		10f. ZIP CODE: 21044	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): JOSPEH GUERIN		18. MOTHER'S NAME (First, Middle, Maiden Surname): LORETTA CAVANAUGH	
19a. INFORMANT'S NAME (Type/Print): DONNA L. CABRAL (DAUGHTER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10810 GREEN VIEW WAY COLUMBIA MARYLAND 21044	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. MARYS CEMETERY 4/6/92	20c. LOCATION — City or Town, State: MIDDLEBOROUGH MASSACHUSETTS	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Eugene W. Witzke	22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOME 5555 TWIN KNOLLS ROAD COLUMBIA MARYLAND 21045		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	1 week
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Aspiration	1 week
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Cerebrovascular Accident	1 month
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Chronic atrial fibrillation	years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Urinary tract infection

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Lois E. Nielsen MD	29c. LICENSE NUMBER: D38327	29d. DATE SIGNED (Month, Day, Year): ▶ 4/2/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LOIS E. NIELSEN MD; 9501 OLD ANNAPOLIS RD SUITE 200; ELLICOTT CITY, 21043

31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alberta Travis

2. DATE OF DEATH: Month 4 Day 2 Year 1992

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 242-36-0757

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 76 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 1-11-1916

8. BIRTHPLACE (State or Foreign Country): S.C.

9a. FACILITY NAME (If not institution, give street and number): Mercy Medical Center

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 10 N. Woodington Road

10f. ZIP CODE: 21229

10g. CITIZEN OF WHAT COUNTRY?: U S A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+):

16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)

16b. KIND OF BUSINESS/INDUSTRY

17. FATNER'S NAME (First, Middle, Last): Sherman Cook

18. MOTNER'S NAME (First, Middle, Maiden Surname): Mary McNeal

19a. INFORMANT'S NAME (Type/Print): Banks C. Mason, Jr

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8600 Doverdale Road Baltimore, Md 21207

20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, other place): Woodlawn Cemetery — DATE: 4692

20c. LOCATION — City or Town, State: Baltimore, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Glynn D. Scott

22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Avenue

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrhythmia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pressure Sores.
Peripheral arterial disease.
Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: George Taler MD

29c. LICENSE NUMBER: D19858

29d. DATE SIGNED (Month, Day, Year): 4/3/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): George Taler, MD 611 S. Charles St. Baltimore, Md. 21230

31. DATE FILED (Month, Day, Year): APR 06 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DARTHELIA L. JONES
2. DATE OF DEATH (Month, Day, Year): 4 3 92
3. TIME OF DEATH: 0758 M
4. SOCIAL SECURITY NUMBER: 214-26-5107
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 3/2/17
8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): STNAT
9b. CITY, TOWN OR LOCATION OF DEATH: BALT.
9c. COUNTY OF DEATH: BALTO.

RESIDENCE OF DECEDENT

10a. STATE: md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balto. md
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2121 Windsor Garden Lane #B221
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.):
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Walter Lewis
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lizzie Jones
19a. INFORMANT'S NAME (Type/Print): Gwendolyn F. Green
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8803 Mission Rd Jessup, md. 20794
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial Park — DATE: 4-7-92
20c. LOCATION — City or Town, State: Randallstown, md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sala March
22. NAME AND ADDRESS OF FACILITY: March Funeral Home West 4300 Wabash Ave. Balto. md. 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. pontine stroke	30d
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. HTN	year
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Syphilis, Abd. Aneurysm

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ethan Dubin MD
29c. LICENSE NUMBER: D35782
29d. DATE SIGNED (Month, Day, Year): 4/3/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ethan Dubin 10211 S Dolfield Rd Owings Mills Md 21117
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

VENDITTI, JOHN A 052803

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 033092

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should accompany within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 29 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN ANTHONY VENDITTI				2. DATE OF DEATH (Month, Day, Year): 04 01 92	3. TIME OF DEATH: 0410 M
4. SOCIAL SECURITY NUMBER: 216-07-1340	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): MAY 28, 1903	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA		9c. COUNTY OF DEATH: HOWARD

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: HOWARD	10c. CITY, TOWN OR LOCATION: COLUMBIA	10d. INSIDE CITY LIMITS? 1 ☐ YES XX NO
10e. STREET AND NUMBER: 10655 GREEN MOUNTAIN CIRCLE		10f. ZIP CODE: 21044	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STORE MANAGER	16b. KIND OF BUSINESS/INDUSTRY: CLOTHING	
17. FATHER'S NAME (First, Middle, Last): MICHELARCANGELO VENDITTI		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIANNINA FERRUCCI	
19a. INFORMANT'S NAME (Type/Print): MARY A. VENDITTI (WIFE)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10655 GREEN MOUNTAIN CIRCLE, COLUMBIA, MARYLAND 21044	
20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY	DATE: 4/6/92	20c. LOCATION — City or Town, State: SILVER SPRING, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Russell Witzke		22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ee cardiec or raspiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PERIORBITAL CELLULITIS / SEPTICEMIA	72 hr
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated event resulting in death) LAST	b. RENAL FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. LIVER FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Marshall Freedman DO	29c. LICENSE NUMBER: H37211	29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARSHALL FREEDMAN, 2 KNOLL N., COLUMBIA, MD 21045		
31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Burdsall-Randall	

DHMH-16 Rev 1/89

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RELEASED AS NON-MED-DR. PERETTI PER MR. HENRY-STATE MEDICAL EXAMINER'S OFFICE ON 4/1/92

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Willie Edward Wilson
2. DATE OF DEATH (Month, Day, Year): APRIL 1, 1992
3. TIME OF DEATH: 10 45 A-M
4. SOCIAL SECURITY NUMBER: 226-44-7271
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 56 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-24-36
8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALT.
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 607 MONTFORD AVE
10f. ZIP CODE: 21205
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABOR
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): HENRY WILSON
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY HARDY WILSON
19a. INFORMANT'S NAME (Type/Print): HELEN BIBBENS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 967 ARGONNE DR BALT MD 21215
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY
20c. LOCATION — City or Town, State: BALT.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Betts Funeral Home
22. NAME AND ADDRESS OF FACILITY: 1129 N. CAROLINE ST BALT 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Atherosclerotic Cardiovascular Disease	YEARS
DUE TO (OR AS A CONSEQUENCE OF):	b. HTN - Hypertension	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c.	
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): NONE
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: D36494
29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David A Brent Johns Hopkins Hospital 600 N Wolfe Baltimore 21205
31. DATE FILED (Month, Day, Year): APR 06 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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92-1825-510

92 09446

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THURMAN B. YATES			2. DATE OF DEATH (Month, Day, Year): 03 30 1992	3. TIME OF DEATH: 11:39 A.M
4. SOCIAL SECURITY NUMBER: 215-46-5170	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 44 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-13-47	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): 1608 E.31 STREET		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore, City	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10a. STREET AND NUMBER: 1608 E. 31st. Street		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Unemployed	16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): Thurman B. Yates Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lorrain Oliver
19a. INFORMANT'S NAME (Type/Print): Lorraine Crosby	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1344 Pentwood Rd./ Baltimore, Md. 21239

20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet. Cem. DATE	20c. LOCATION — City or Town, State: Owings Mills, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Monica Gatlin	22. NAME AND ADDRESS OF FACILITY: Wm.C. March F/H 1101 E. North Ave.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gunshot Wound of Head DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 X Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 03-30-1992	28b. TIME OF INJURY: 10:26A.M	28c. INJURY AT WORK? 1 ☐ YES 2 X NO	28d. DESCRIBE HOW INJURY OCCURED: SUBJECT SHOT
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): AT HOME			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1608 E.31 STREET

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶03-31-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK J. PERETTI	111 PENN STREET BALTIMORE MARYLAND 21201	
31. DATE FILED (Month, Day, Year): APR 06 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

841

92 09447

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): STERLING E. YINGLING, JR.

2. DATE OF DEATH — MONTH: 4 DAY: 4 YEAR: 92

3. TIME OF DEATH: 7:15 PM

4. SOCIAL SECURITY NUMBER: 213-05-3009

5. SEX: 1 [X] M 2 [ ] F

6. AGE (If yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): MAR 01 1914

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 3523 WILKENS AVE

10f. ZIP CODE: 21229

10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): H.S.GRAD — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): GUARD

16b. KIND OF BUSINESS/INDUSTRY: U.S.GOVERNMENT (SOC.SEC.)

17. FATHER'S NAME (First, Middle, Last): STERLING E. YINGLING

18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN

19a. INFORMANT'S NAME (Type/Print): GRACE YINGLING

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3523 WILKENS AVE, BALTIMORE, MD 21229

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY — DATE: 4-08

20c. LOCATION — City or Town, State: BALTIMORE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Louis E. Smith

22. NAME AND ADDRESS OF FACILITY: HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE, BALTIMORE, MD 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Renal Failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Metastatic Carcinoma of prostate

DUE TO (OR AS A CONSEQUENCE OF):

c. DIC

DUE TO (OR AS A CONSEQUENCE OF):

d. CHF

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M Chair, MD

29c. LICENSE NUMBER: St. Agnes

29d. DATE SIGNED (Month, Day, Year): 4/4/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Chair, St Agnes 3900 Caton Ave, Baltimore, MD

31. DATE FILED (Month, Day, Year): APR 06 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

10+1

Item 19a, Per Informant, G-687, 5/28/92 gn

92 09448

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 3/3

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALI ZAMANI — ALI ZAMANI

2. DATE OF DEATH Month: 3 Day: 18 Year: 92

3. TIME OF DEATH: 9:05 A M

4. SOCIAL SECURITY NUMBER: 578 96 7576

5. SEX: 1 X M 2 ☐ F

6. AGE (In yrs. last birthday): 37 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 09/01/54

8. BIRTHPLACE (State or Foreign Country): IRAN

9a. FACILITY NAME (If not institution, give street and number): JOHNS HOPKINS HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: BALT. MD

9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: MONTGOMERY

10c. CITY, TOWN OR LOCATION: GAITHERSBURG

10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO

10e. STREET AND NUMBER: 339 Wye Mill Court

10f. ZIP CODE: 20879

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 X NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: IRANIAN
IRANIAN

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+): 6

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PROFESSOR

16b. KIND OF BUSINESS/INDUSTRY: George Washington University

17. FATHER'S NAME (First, Middle, Last): HOSSENIE ZAMANI

18. MOTHER'S NAME (First, Middle, Maiden Surname): SOGRA MONANIY

19a. INFORMANT'S NAME (Type/Print): Nadereh Kashani-Siadat Zamani (Wife)

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 724 Clopper Road #12, Gaithersburg, Md. 20878

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Tehran — DATE: 3/21

20c. LOCATION — City or Town, State: TEHRAN, IRAN

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Alex S. Pope Jr M859

22. NAME AND ADDRESS OF FACILITY: ALEXANDER S. POPE FUNERAL HOME
2617 Pennsylvania Avenue, SE DC 20020

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such es cerdiec or reapiretory errest, ahock, or heart failure. List only ona cause on aech line.

Approximate Interval Between Onsat and Dasth

IMMEDIATE CAUSE (Final disease or condition resulting in deeth) → a. CARDIO-PULMONARY ARREST — 1 month

DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if sny, leading to immediate csuse. Enter UNDERLYING CAUSE (Diseese or injury that initieted events resulting in death) LAST

b. PULMONARY EDEMA

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year)

26b. TIME OF INJURY M

26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

26d. DESCRIBE HOW INJURY OCCURED

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Christopher E. Walsh

29c. LICENSE NUMBER: MD1334894

29d. DATE SIGNED (Month, Day, Year): 3/18/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHRISTOPHER WALSH JOHNS HOPKINS HOSP. BALT. MD

31. DATE FILED (Month, Day, Year): MAR 19 1992

32. REGISTRAR'S SIGNATURE: [illegible]

DHMH-16 Rev 1/89

92-1324-033 Items: 23 part I,27,28a,b,c,d,e,f per MEO G-686 92 09449

1 - FOR STATE REGISTRAR 4/8/92 reb

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 5 should be detached for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rahsaan Adbul Al-Haaziq — AKA: HAAZIQ

2. DATE OF DEATH (Month, Day, Year): 03 08 1992

3. TIME OF DEATH: 9:30 PM

4. SOCIAL SECURITY NUMBER: 241-38-8175

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 58 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Jan 7,1933

8. BIRTHPLACE (State or Foreign Country): Durham,N.C.

9a. FACILITY NAME (If not institution, give street and number): 404 Larchmont Avenue

9b. CITY, TOWN OR LOCATION OF DEATH: Capitol Heights

9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: NA

10b. COUNTY: NA

10c. CITY, TOWN OR LOCATION: WASHINGTON, D.C.

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 1835 18th St.,S.E.

10f. ZIP CODE: 20020

10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. OECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+): 1

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TAILOR

16b. KIND OF BUSINESS/INDUSTRY: CLOTHING

17. FATHER'S NAME (First, Middle, Last): JOHN RUSSELL

18. MOTHER'S NAME (First, Middle, Maiden Surname): ANITA UNK

19a. INFORMANT'S NAME (Type/Print): IDA HAAZIQ (WIFE)

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3510 Silver Park Drive #14,Suitland, Md. 20746

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): HARMONY MEMORIAL PARK — DATE: 3/14

20c. LOCATION — City or Town, State: LANDOVER, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Alex S. Pope Jr — M859

22. NAME AND ADDRESS OF FACILITY: ALEXANDER S. POPE FUNERAL HOME, 2617 Pennsylvania Avenue,SE DC 20020

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Intravenous Narcotic and Ethyl Alcohol intoxication
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending Investigation 6 [X] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): FOUND: 3/8/92

28b. TIME OF INJURY: found: 8:20 P.M.

28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO

28d. DESCRIBE HOW INJURY OCCURED: Subject used drugs & ethyl alcohol

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): found: House

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 404 Larchmont Ave. Capitol Heights, Md.

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis J Clark MD

29c. LICENSE NUMBER: O.C.M.E.

29d. DATE SIGNED (Month, Day, Year): 03 09 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 111 Penn Street, Baltimore Maryland 21201

31. DATE FILED (Month, Day, Year): MAR 17 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09450

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH GOLDIE ADKINS
2. DATE OF DEATH: MONTH 03 DAY 11 YEAR 92
3. TIME OF DEATH: 3:00 P M
4. SOCIAL SECURITY NUMBER: 214-10-6332
5. SEX: 1 ☐ M 2 ☒ F (XX)
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-3-07
8. BIRTHPLACE (State or Foreign Country): WILMINGTON, DE
9a. FACILITY NAME (If not institution, give street and number): #11 FRANKLIN SQUARE
9b. CITY, TOWN OR LOCATION OF DEATH: BERLIN, MD
9c. COUNTY OF DEATH: WORCESTER

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: WORCESTER
10c. CITY, TOWN OR LOCATION: OCEAN CITY
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO (XX)
10e. STREET AND NUMBER: 266 F BALTE RD.
10f. ZIP CODE: 21842
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed (XX) 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO (XX) IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO (XX) Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 yrs. — College (1-4 or 5+): --
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: NONE
17. FATHER'S NAME (First, Middle, Last): WALTER E. HILYARD
18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH SEIDEL
19a. INFORMANT'S NAME (Type/Print): NORMAN SMITH (SON)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 921 S. DuPONT BLVD. MILFORD, DELAWARE 19963
20a. METHOD OF DISPOSITION: 1 ☒ Burial (XX) 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): WICOMICO MEMORIAL PARK — DATE: 3/14
20c. LOCATION — City or Town, State: SALISBURY, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John N. Holloway
22. NAME AND ADDRESS OF FACILITY: HOLLOWAY FUNERAL HOME 501 SNOW HILL RD. SALISBURY, MD. 21801

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Squamous Cell Carcinoma of Anus — Approximate Interval Between Onset and Death: 10 years

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO (XX)
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO (XX)
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence (XX) 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural (X) 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (X)
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D.
29c. LICENSE NUMBER: 03069
29d. DATE SIGNED (Month, Day, Year): 3/13/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James E. Martin M.D. 145 E. Carroll St. Salisbury, MD
31. DATE FILED (Month, Day, Year): MAR 17 1992
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92-09451

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VESTINE ANN ALBAUGH				2. DATE OF DEATH (Month, Day, Year): Mar. 24, 1992	3. TIME OF DEATH: 3:30PM M
4. SOCIAL SECURITY NUMBER: 220-48-0019	5. SEX: 1 ☐ MALE 2 ☒ FEMALE	6. AGE (In yrs. last birthday): 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 07/31/00	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): CARROLL COUNTY GENERAL HOSP.			9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER		9c. COUNTY OF DEATH: CARROLL

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: CARROLL	10c. CITY, TOWN OR LOCATION: KEYMAR	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 2429 FRANCIS SCOTT KEY HGWY.		10f. ZIP CODE: 21757	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced — Widowed	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: NO	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): EMORY HONTS		18. MOTHER'S NAME (First, Middle, Maiden Surname): MINNIE (UNKNOWN)	
19a. INFORMANT'S NAME (Type/Print): GEORGE F. ALBAUGH		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2120 KEYSVILLE-FRED.KEYMAR MD 21757	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BURIAL	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. HOPE CEMETERY	20c. LOCATION — City or Town, State: WOODSBORO, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Catherine O. Hartzler		22. NAME AND ADDRESS OF FACILITY: D. D. HARTZLER & SONS WOODSBORO, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary Embolus	3 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ~~Severe~~ hypovolemic error	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe hypovolemia

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
D. Alexander Rocha MD	D36112	▶ 3-25-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D. ALEXANDER ROCHA 4500 BLACKROCK RD. HAMPSTEAD, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 27 '92	Linda Davidson-Kimmel

DHMH-16 Rev 1/89

92 09452

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 5 and 6 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BOOKER T. AVERY			2. DATE OF DEATH (Month, Day, Year): 2/21/92	3. TIME OF DEATH: 2.30AM M
4. SOCIAL SECURITY NUMBER: 577-07-5813	5. SEX: 1 ☐ M 2 ☐ F (X)	6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 27, 1905	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSP CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGE
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Hyattsville		10d. INSIDE CITY LIMITS? 1 (X) YES 2 ☐ NO
10e. STREET AND NUMBER: 7305 Adelphi Road		10f. ZIP CODE: 20783		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 (X) Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 (X) NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 (X) NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cab Driver		16b. KIND OF BUSINESS/INDUSTRY: Private Industry
17. FATHER'S NAME (First, Middle, Last): Eugene Avery		18. MOTHER'S NAME (First, Middle, Maiden Surname):		
19a. INFORMANT'S NAME (Type/Print): Carrie S. Taylor		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7305 Adelphi Rd., Hyattsville, Md. 20783		
20a. METHOD OF DISPOSITION: 1 (X) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Wesley Chapel Ch. Cemetery DATE 2/		20c. LOCATION — City or Town, State: Johnson City, N. C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Julia G Horton		22. NAME AND ADDRESS OF FACILITY: R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, N. W.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	congestive Ident Failure	1 week
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Acute Renal Failure	3 week
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Obstructive Uropathy	3 week
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pneumonia Anemia Old cerebro-vascular accident

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 (X) NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 (X) Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 (X) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Attending Physician	29c. LICENSE NUMBER: D 20079	29d. DATE SIGNED (Month, Day, Year) ▶ 2/21/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Don H. Yablonowitz, MD 10300 Greenbelt Rd. #101, Seabrook, MD 20706		
31. DATE FILED (Month, Day, Year): MAR 20 '92	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

92 09453

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Luis Angel Amaya

2. DATE OF DEATH Month: 3 Day: 9 Year: 92

3. TIME OF DEATH: 9:50 P M

4. SOCIAL SECURITY NUMBER: None

5. SEX: 1 ☒ M 2 ☐ F

6. AGE (In yrs. last birthday) YRS.: IF UNDER 1 YEAR — MONTHS: DAYS: IF UNDER 24 HRS. — HOURS: 1 MIN.:

7. DATE OF BIRTH (Month, Day, Year): March 9, 1992

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Silver Spring

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 8902 Manchester Road, #308

10f. ZIP CODE: 20901

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ YES 2 ☐ NO Specify: El Salvadoran

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None

16b. KIND OF BUSINESS/INDUSTRY: None

17. FATHER'S NAME (First, Middle, Last): Jose Portillo

18. MOTHER'S NAME (First, Middle, Maiden Surname): Vilma Nohemy

19a. INFORMANT'S NAME (Type/Print): Russell P. Duke

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13537 Demetris Way, Germantown, MD 20874

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory — DATE: 3-13

20c. LOCATION — City or Town, State: Silver Spring, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen H. Rapp

22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirstory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Extreme immaturity

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initistad events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): N/A

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Katherine C. White, MD Staff Neonatologist

29c. LICENSE NUMBER: D28737

29d. DATE SIGNED (Month, Day, Year): ▶ 3/9/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Katherine C. White MD Holy Cross Hosp. 1500 Forest Glen Rd Silver Spring MD 20910

31. DATE FILED (Month, Day, Year): MAR 20 '92

32. REGISTRAR'S SIGNATURE: Julia Davidson Rader

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09454
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Jack JACK H. ANDONIAN					2. DATE OF DEATH MONTH 3 DAY 18 YEAR 92	3. TIME OF DEATH 3:00 P.M.
4. SOCIAL SECURITY NUMBER 015-20-9443	5. SEX 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) MAY 27, 1927	8. BIRTHPLACE (State or Foreign Country) MASSACHUSETTS
9a. FACILITY NAME (If not institution, give street and number) 3001 KINGSWELL DRIVE			9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT						
10a. STATE MARYLAND	10b. COUNTY MONTGOMERY	10c. CITY, TOWN OR LOCATION SILVER SPRING			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO	
10e. STREET AND NUMBER 3001 KINGSWELL DRIVE		10f. ZIP CODE 20902			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES REPRESENTATIVE			16b. KIND OF BUSINESS/INDUSTRY FLOORING & CARPETING	
17. FATHER'S NAME (First, Middle, Last) BOGHUS ANDONIAN					18. MOTHER'S NAME (First, Middle, Maiden Surname) SIRANOOSH NAJARIAN	
19a. INFORMANT'S NAME (Type/Print) CLARA K. ANDONIAN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 KINGSWELL DRIVE, SILVER SPRING, MD 20902				
20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARKLAWN CEMETERY	DATE 3/21		20c. LOCATION — City or Town, State ROCKVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ray D Ba		22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 2090				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiovascular Disease.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER D0854[illegible]

29d. DATE SIGNED (Month, Day, Year) 3-18-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Taubman 8218 Wisconsin Ave Bethesda

31. DATE FILED (Month, Day, Year) MAR 19 1992

32. REGISTRAR'S SIGNATURE Gloria Davidson-Randall

10+1

DHMH-16 Rev 1/89

92-1441-510

92 09455

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 4 is designed for use as the burial-transit permit. Pages 1, 2, 3 should
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERICK LOUIS BROWN, 2nd					2. DATE OF DEATH (Month, Day, Year): 03 13 1992	3. TIME OF DEATH: 11:54 A M	
4. SOCIAL SECURITY NUMBER: N/A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS 2 / DAYS 11	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 01 02 1992	8. BIRTHPLACE (State or Foreign Country): Maryland	
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY			9c. COUNTY OF DEATH: PRINCE GEORGE	
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Prince George's		10c. CITY, TOWN OR LOCATION: Largo			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 241 Harry S. Truman Drive, #21			10f. ZIP CODE: 20772			10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Afro American	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A			16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A			16b. KIND OF BUSINESS/INDUSTRY: N/A	
17. FATHER'S NAME (First, Middle, Last): Erick L. Brown, Sr.					18. MOTHER'S NAME (First, Middle, Maiden Surname): Melissa North		
19a. INFORMANT'S NAME (Type/Print): Erick L. Brown, Sr.			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 241 Harry S. Truman Dr.,#21, Largo, Md. 20772				
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery DATE: 03-17-92			20c. LOCATION — City or Town, State: Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]			22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave.,Hyattsville, Md 20781				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SUDDEN INFANT DEATH SYNDROME	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: O.C.M.E | 29d. DATE SIGNED (Month, Day, Year): 03-14-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARIO F. GOLLE JR. MD 111 N. PENN ST. BALTIMORE,MARYLAND 21201

31. DATE FILED (Month, Day, Year): MAR 17 1992

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

(3)

OHMH-16 Rev 1/89

asp

92 09456

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harry James Barton, Sr.		2. DATE OF DEATH (Month, Day, Year): 3 / 15 / 92	3. TIME OF DEATH: 6:50 PM M
4. SOCIAL SECURITY NUMBER: 340-09-8976	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 87 YRS. (If under 1 year: Months, Days, Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 1, 1904 / 8. BIRTHPLACE (State or Foreign Country): Illinois
9a. FACILITY NAME (If not institution, give street and number): Bradford Oaks Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Clinton	9c. COUNTY OF DEATH: Prince George's	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Clinton	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 8001 Poplar Hill Drive	10f. ZIP CODE: 20735	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th / College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fire Fighter	16b. KIND OF BUSINESS/INDUSTRY: U.S. Government	
17. FATHER'S NAME (First, Middle, Last): John Barton	18. MOTHER'S NAME (First, Middle, Maiden Surname): Claire Garmer		
19a. INFORMANT'S NAME (Type/Print): Janis Chambers	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10 A-F		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery	20c. LOCATION — City or Town, State: Clinton, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md 20735		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MALIGNANT LYMPHOMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D-18545	29d. DATE SIGNED (Month, Day, Year): 3/15/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P. Wisotsky M.D.		
31. DATE FILED (Month, Day, Year): MAR 19 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMN-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09457
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be signed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM BARLOW					2. DATE OF DEATH (Month / Day / Year): 3 / 13 / 92	3. TIME OF DEATH: 7:00 A M
4. SOCIAL SECURITY NUMBER: 227-12-2409	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept. 9, 1922	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): GLADYS SPELLMAN NURSING HOME			9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PG	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Capitol Heights	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1903 Clark Place		10f. ZIP CODE: 20743	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction	16b. KIND OF BUSINESS/INDUSTRY: Private	
17. FATHER'S NAME (First, Middle, Last): Joseph Barlow		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Whitten	
19a. INFORMANT'S NAME (Type/Print): Thelma Childress		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1903 Clark Pl., Capitol Hgts., MD.	

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans	DATE: 3/19	20c. LOCATION — City or Town, State: Cheltenham, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John T. Stewart, III		22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 4001 Benning Rd., N.E. Wash. D.C.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Anoxic Encephalopathy	1 month
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Status Epilepticus	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jon H. Yablonovitz, Medical Director		29c. LICENSE NUMBER: D25077	29d. DATE SIGNED (Month, Day, Year): ▶ 3/14/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JON N. YABLONOVITZ, MD 10300 Greenbelt Rd., Suite 101 Seabrook MD 20706

31. DATE FILED (Month, Day, Year): MAR 18 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

2

DHMH-16 Rev 1/89

92 09458

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Barbara L. Barnaby			2. DATE OF DEATH MONTH 3 DAY 15 YEAR 92		3. TIME OF DEATH 620 PM
4. SOCIAL SECURITY NUMBER 578-42-5717	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 59	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 9-23-32	8. BIRTHPLACE (State or Foreign Country) New York
9a. FACILITY NAME (If not institution, give street and number) Leland Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH RIVERDALE		9c. COUNTY OF DEATH PRINCE GEORGES	

RESIDENCE OF DECEDENT

10a. STATE MD	10b. COUNTY PRINCE GEORGES	10c. CITY, TOWN OR LOCATION MT RANIER	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER 2400 QUEEN CHAPEL ROAD APT #11		10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12th; College (1-4 or 5+): 1 yr	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary	16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) Franklin T. Mills	18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophie Young		
19a. INFORMANT'S NAME (Type/Print) Sophie Y. Smith	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1333 Florida Avenue, N. W. Washington, DC 20001		
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Lincoln Memorial Cemetery	DATE 3-20	20c. LOCATION — City or Town, State Suitland Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ J. P. Marshall	22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home Inc. 4217 9th Street, N. W., Washington, D. C. 20011		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death: MINUTES minutes

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Arteriosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

CARDIAC ARRHYTHMIA

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) NIA N/A	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Paul A. DeVore MD Deputy Medical Examiner	29c. LICENSE NUMBER D01852	29d. DATE SIGNED (Month, Day, Year) ▶ 3-15-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL A. DEVORE, MD 4203 QUEENSBURY RD. RIVERDALE MD 20737			
31. DATE FILED (Month, Day, Year) MAR 18 1992	32. REGISTRAR'S SIGNATURE Lisha Davidson-Randall		

DHMH-18 Rev 1/89

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92 09459

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be obtained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 signed by, detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LIZA ANN BROWN				2. DATE OF DEATH (Month, Day, Year): MARCH 26, 1992	3. TIME OF DEATH: 6:46 PM M
4. SOCIAL SECURITY NUMBER: 579-12-6540-B	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): AUG. 23, 1912	8. BIRTHPLACE (State or Foreign Country): SOUTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH: LA PLATA	9c. COUNTY OF DEATH: CHARLES

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: CHARLES	10c. CITY, TOWN OR LOCATION: PISGAH	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: ROUTE #425		10f. ZIP CODE: 20640	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4TH GRADE; College (1-4 or 5+): NONE	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: PRIVATE	
17. FATHER'S NAME (First, Middle, Last): CHARLIE JONES		18. MOTHER'S NAME (First, Middle, Maiden Surname): JOSIE BLAIR JONES	
19a. INFORMANT'S NAME (Type/Print): RALLIE BROWN JR.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): ROUTE #2 BOX 79 Y INDIAN HEAD, MARYLAND 20640		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY	DATE: 4/1/92	20c. LOCATION — City or Town, State: SUITLAND, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lydia C. Thornton Johnson LYDIA C. THORNTON JOHNSON	22. NAME AND ADDRESS OF FACILITY: THORNTON'S FUNERAL HOME, POMONKEY, MARYLAND		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIAC ARREST	>10
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. HYPERTENSION	YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Krishan M. Mathur	29c. LICENSE NUMBER: D-28352	29d. DATE SIGNED (Month, Day, Year): 3 27 92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KRISHAN M. MATHUR M.D. PEMBROOKE SQUARE #213 HIGHWAY 301 SOUTH WALDORF MD. 20603

31. DATE FILED (Month, Day, Year): MAR 27 92	32. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall

DHMH-16 Rev 1/89

92 09460

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Vida Marie Bradshaw
2. DATE OF DEATH (Month, Day, Year): 03 25 92
3. TIME OF DEATH: 4:30 PM
4. SOCIAL SECURITY NUMBER: 195 05 3416
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 92 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 03-18-1900
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hosp
9b. CITY, TOWN OR LOCATION OF DEATH: Fallston MD
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: HARFORD
10c. CITY, TOWN OR LOCATION: BEL AIR
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1522 SOUTHVIEW ROAD
10f. ZIP CODE: 21015
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CAFETERIA WORKER
16b. KIND OF BUSINESS/INDUSTRY: FOOD PREPARATION
17. FATHER'S NAME (First, Middle, Last): WILLIAM HAMILTON
18. MOTHER'S NAME (First, Middle, Maiden Surname): HATTIE THOMPSON
19a. INFORMANT'S NAME (Type/Print): BARBARA H. COATES
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1522 SOUTHVIEW RD., BEL AIR, MD. 21015
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): DARLINGTON CEMETERY — DATE: 3/28
20c. LOCATION — City or Town, State: DARLINGTON, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John H. Tillett
22. NAME AND ADDRESS OF FACILITY: HARKINS F.H. INC., DELTA, PA., 17314

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. [illegible]
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. [illegible] Hypertonia Wall MI
DUE TO (OR AS A CONSEQUENCE OF): Revd (MD)
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] NAIR
29c. LICENSE NUMBER: D.16444
29d. DATE SIGNED (Month, Day, Year): ▶ 3/25/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V. NAIR. 2112 Belair Road - Fallston MD 21047.
31. DATE FILED (Month, Day, Year): MAR 27 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Mitchell

OHMH-16 Rev 1/89

92-1302-011

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09461

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be detached by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
WILLIAM	PAUL	BAKER	SR.	03 06 1992	5:15 P.M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR / IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
221-28-1567	1 [X] M 2 [ ] F	48 YRS.	MONTHS / DAYS / HOURS / MIN.	04-11-43	MILTON, DE
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
MEMORIAL HOSPITAL AT EASTON		EASTON		CAROLINE	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
DELAWARE	SUSSEX	BRIDGEVILLE	1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER		10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
407 C DELAWARE AVE		19933	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	1 [ ] YES 2 [X] NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		FUEL TRUCK DRIVER	OIL INDUSTRY

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
WILLIS PAUL BAKER	MARIETTA DONOVAN BAKER
19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CLARA BAKER	407 C DELAWARE AVE., BRIDGEVILLE DE

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	ODD FELLOWS CEM.	3/12	MILTON, DE
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY	
▶ George M Short		SHORT FUNERAL SERVICES INC PO BOX 233, MILTON DE 19968	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Chest Injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) 03-06-1992	28b. TIME OF INJURY 3:50P.M	28c. INJURY AT WORK? 1 [X] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED DRIVER IN MOTOR VEHICLE ACCIDENT
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ON ROAD			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) AMERICAN CORNER ROAD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. CATE SIGNED (Month, Day, Year)
J. Aaron Locke MD	O.C.M.E.	▶ 03-07-1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
J. AARON LOCKE, MD	111 PENN STREET BALTIMORE MARYLAND 21201	
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	
MAR 17 1992	Julia Davidson-Randall	

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DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rachel A. Brown				2. DATE OF DEATH: MONTH March DAY 13 YEAR 1992	3. TIME OF DEATH: 1015 M
4. SOCIAL SECURITY NUMBER: 215-16-8113	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-18-1916	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY		9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Wicomico	10c. CITY, TOWN OR LOCATION: Mardela	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 2 Box 633		10f. ZIP CODE: 21837	10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic	16b. KIND OF BUSINESS/INDUSTRY: None	
17. FATHER'S NAME (First, Middle, Last): Charles Dashiell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Addie Wheatley	
19a. INFORMANT'S NAME (Type/Print): Carolyn Sturgis	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt.2 Box 633 Mardela, Md. 21837		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Green Acres — DATE	20c. LOCATION — City or Town, State: Salisbury Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys B. Stewart	22. NAME AND ADDRESS OF FACILITY: 821 West Rd. Clinton F. Stewart-Salis. Md. 21801		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. cardiopulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Bowel obstruction	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Bowel infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

morbid obesity
Pulmonary Atelectasis
" air fat Embolism

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D57670	29d. DATE SIGNED (Month, Day, Year) ▶ 3/13/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M.L.M. Evangelista	105 Pine Bluff Rd #6 Salisbury, Md. 21804	
31. DATE FILED (Month, Day, Year): MAR 16 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

92 09463

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SAMUEL W. BOWEN			2. DATE OF DEATH (Month, Day, Year): MARCH 14, 1992	3. TIME OF DEATH: 0155 M
4. SOCIAL SECURITY NUMBER: 215-38-1069	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3/21/02	8. BIRTHPLACE (State or Foreign Country): BERLIN
9a. FACILITY NAME (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY		9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: WORCESTER	10c. CITY, TOWN OR LOCATION: BERLIN	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: RTE. #4, BOX 462		10f. ZIP CODE: 21811	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER	16b. KIND OF BUSINESS/INDUSTRY: FARMER	
17. FATHER'S NAME (First, Middle, Last): SAMUEL W. BOWEN, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARTHA ELLEN FOREMAN	
19a. INFORMANT'S NAME (Type/Print): CONSUELLA FITCHETT		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 408 FLOWER STREET., BERLIN, MD. 21811	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): EVERGREEN	DATE: 3-19	20c. LOCATION — City or Town, State: BERLIN, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Loretta B. Jolley		22. NAME AND ADDRESS OF FACILITY: JOLLEY MEMORIAL CHAPEL, RTE. 2, BOX 920 SALISBURY, MD. 21801	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: 34768	29d. DATE SIGNED (Month, Day, Year): 3/14/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 560 Riverside Dr Salisbury, Md 21801		
31. DATE FILED (Month, Day, Year): MAR 19 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

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DHMH-18 Rev 1/89

92 09464

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-[illegible]

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) HENDERSON HASSELL BELL, JR		2. DATE OF DEATH Month: 3. Day: 22 Year: 92	3. TIME OF DEATH 9:15 PM
4. SOCIAL SECURITY NUMBER 236-26-7230	5. SEX 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year) 12-4-21	8. BIRTHPLACE (State or Foreign Country) W. VIRGINIA		
9a. FACILITY NAME (If not institution, give street and number) MANOR CARE LARGO	9b. CITY, TOWN OR LOCATION OF DEATH LARGO	9c. COUNTY OF DEATH PRINCE GEORGES	

RESIDENCE OF DECEDENT

10a. STATE MD	10b. COUNTY Prince Georges	10c. CITY, TOWN OR LOCATION Upper Marlboro	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER 9115 Lot #39 Marlboro Pike	10f. ZIP CODE 20772	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) GVT. EMPLOYEE	16b. KIND OF BUSINESS/INDUSTRY FED GOV.	
17. FATHER'S NAME (First, Middle, Last) HENDERSON H BELL, SR	18. MOTHER'S NAME (First, Middle, Maiden Surname) Norma Hager		
19a. INFORMANT'S NAME (Type/Print) Terrance Bell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 915, Bryans Road, Md. 20616		
20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery	DATE	20c. LOCATION — City or Town, State 3-26-Cheltenham, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Benjamin Matthews MD0658	22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home P. O. Box 156, Waldorf, Md. 20604		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebrovascular Accident	3 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Carotid artery stenosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. diffuse atherosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery disease
abdominal Aortic Aneurysm
hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Eleanor Stewart MD	29c. LICENSE NUMBER D 30786	29d. DATE SIGNED (Month, Day, Year) ▶ 3-23-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ELEANOR S. STEWART, M.D. 5700 Auth Way Suitland, MD 20746

31. DATE FILED (Month, Day, Year) MAR 25 '92	32. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09465

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VONDA BEULA BOSIN (VONDA BOSIN)
2. DATE OF DEATH (Month, Day, Year): 03-22-92
3. TIME OF DEATH: 6:25P M
4. SOCIAL SECURITY NUMBER: 577-01-7176
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): NOV. 9, 1911
8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): WASHINGTON ADVENTIST NURSING HOME
9b. CITY, TOWN OR LOCATION OF DEATH: TAKOMA PARK
9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: MONTGOMERY
10c. CITY, TOWN OR LOCATION: SILVER SPRING
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 1031 RUATAN STREET
10f. ZIP CODE: 20903
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RECEPTIONIST
16b. KIND OF BUSINESS/INDUSTRY: GROUP HEALTH
17. FATHER'S NAME (First, Middle, Last): HARRY STEVENS
18. MOTHER'S NAME (First, Middle, Maiden Surname): CARRIE SMITH
19a. INFORMANT'S NAME (Type/Print): MORRIS L. BOSIN (HUSBAND)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1031 RUATAN STREET, SILVER SPRING, MD 20903
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY — DATE:
20c. LOCATION — City or Town, State: ALEXANDRIA, VIRGINIA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Andrew J. Cole
22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetions thet ceused the deeth. Do not enter the mode of dying, such ee cerdiec or reepiratory errest, shock, or heart feilure. List only one ceuse on eech line.

		Approximate Interval Between Oneet end Deeth
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentlelly liet conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in deeth) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditione contributing to deeth but not reeulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF OEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. OESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Gary W. Jones, MD
29c. LICENSE NUMBER: D30111
29d. DATE SIGNED (Month, Day, Year): 3-22-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): Gary W. JONES, M.D. P.O. Box 385 Laurel, Md 20725
31. DATE FILED (Month, Day, Year): MAR 24 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

92 09466

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH BURGER			2. DATE OF DEATH: MONTH 3 DAY 21 YEAR 92	3. TIME OF DEATH: 1:00P M
4. SOCIAL SECURITY NUMBER: 577-26-5413	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): JULY 18, 1919	8. BIRTHPLACE (State or Foreign Country): AUSTRIA
9a. FACILITY NAME (If not institution, give street and number): MANOR CARE		9b. CITY, TOWN OR LOCATION OF DEATH: WHEATON		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 15101 INTERLACHEN DR. #321		10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALESMAN	16b. KIND OF BUSINESS/INDUSTRY: AUTOMOBILES	
17. FATHER'S NAME (First, Middle, Last): SOLOMON BURGER		18. MOTHER'S NAME (First, Middle, Maiden Surname): GUSTA LOWENWIRTH	
19a. INFORMANT'S NAME (Type/Print): HANNAH BURGER (WIFE)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15101 INTERLACHEN DR., #321 SILVER SPRING, MD 20906	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): JUDEAN MEMORIAL GARDENS DATE 3/23	20c. LOCATION — City or Town, State: OLNEY, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank A. Stone		22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. AMYOTROPHIC LATERAL SCLEROSIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kathleen K. Davis MD	29c. LICENSE NUMBER: D37096	29d. DATE SIGNED (Month, Day, Year) ▶ 3/24/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KATHLEEN K. DAVIS 8700 GEORGIA AVE SILVER SPRING MD 20910

31. DATE FILED (Month, Day, Year): MAR 23 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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DHMH-16 Rev 1/89

92 09467

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERTHA M. BURKETT (BERTHA M. BURKETT)
2. DATE OF DEATH (Month, Day, Year): 03 21 1992
3. TIME OF DEATH: 0414 A M
4. SOCIAL SECURITY NUMBER: 578363740
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-9-1916
8. BIRTHPLACE (State or Foreign Country): N. Carolina
9a. FACILITY NAME (If not Institution, give street and number): Washington Adventist Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Silver Spring
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 12601 Eastbourne Drive
10f. ZIP CODE: 20904
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR OATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indien, Black, White, etc. Specify: White
15. DECEOENT'S EOUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1-12; College (1-4 or 5+): 4 years
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant
16b. KIND OF BUSINESS/INDUSTRY: U.S. Govt.,
17. FATHER'S NAME (First, Middle, Last): John Pearce
18. MOTHER'S NAME (First, Middle, Maiden Surname): Melisa Mae
19a. INFORMANT'S NAME (Type/Print): Carol F. Divver,
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12601 Eastbourne Dr., Silver Spring, Md. 20904
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National — DATE: 3-25-92
20c. LOCATION — City or Town, State: Arlington, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Philip D Rinaldi
22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home, 11800 N.H. Ave., Silver Spring, Md. 20904

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hypertrophic cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary disease
CARCINOMA OF BREAST
DIABETES MELLITUS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Pamela Mulshine MD
29c. LICENSE NUMBER: D25009
29d. DATE SIGNED (Month, Day, Year): ▶ 3/21/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Pamela Mulshine 11161 New Hampshire Ave Silver Spring
31. DATE FILED (Month, Day, Year): MAR 24 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson Rogers

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 09468

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CAROLINE JOSEPHINE LEONARDO BAISDEN			2. DATE OF DEATH (Month, Day, Year): 3/23/92	3. TIME OF DEATH: 4:18 A M
4. SOCIAL SECURITY NUMBER: 578-60-4905	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3-18-1900	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring,		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring,	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 15400 Short Ridge Court		10f. ZIP CODE:	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1-12; College (1-4 or 5+): B.S Nursing	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NUrsing Supervisor	16b. KIND OF BUSINESS/INDUSTRY: Childrens Hospital	
17. FATHER'S NAME (First, Middle, Last): Enrico Leonardo	18. MOTHER'S NAME (First, Middle, Maiden Surname): Maria Vincenza Branca		
19a. INFORMANT'S NAME (Type/Print): Louis Baisden	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15400 Short Ridge Court, Silver Spring, Md.		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery DATE: 3-25-92	20c. LOCATION — City or Town, State: Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Clark E Wood	22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. 20904		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Pulmonary Edema	3/21/92
DUE TO (OR AS A CONSEQUENCE OF): b.	Dehydration	3/21/92
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Chronic Renal Failure	1991
d.	Congestive Heart Failure	1991

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Anemia, ASCVD

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: N/A M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: GB Pottick III MD	29c. LICENSE NUMBER: D 17759	29d. DATE SIGNED (Month, Day, Year): ▶ 3/23/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): G B Pottick III MD 9221 Colesville Rd SS, Md 20910		
31. DATE FILED (Month, Day, Year): MAR 24 92	32. REGISTRAR'S SIGNATURE: [illegible] Randall	

DHMH-16 Rev 1/89

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92-1665-031

Items: 23 part I,27,28a,b,c,d,e,f per MEO G-686 92 09469

1 - FOR STATE REGISTRAR 4/8/92 reb

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN ROBERT BERG				2. DATE OF DEATH (Month / Day / Year): 03 / 21 / 92	3. TIME OF DEATH: 4:15 AM
4. SOCIAL SECURITY NUMBER: 218-66-3148	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 36 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 11, 1955	8. BIRTHPLACE (State or Foreign Country): Minnesota
9a. FACILITY NAME (If not institution, give street and number): 11415 COMMONWEALTH DRIVE			9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11415 Commonwealth Drive, #T-1		10f. ZIP CODE: 20852	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chief Engineer	16b. KIND OF BUSINESS/INDUSTRY: Heating & Air Conditioning
17. FATHER'S NAME (First, Middle, Last): Robert Berg		18. MOTHER'S NAME (First, Middle, Maiden Surname): Inez LaFain Webster	
19a. INFORMANT'S NAME (Type/Print): Vicki Lee Berg		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13403 Dowlais Drive, Rockville, MD 20853	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Norbeck Memorial Park	DATE: 3-25
			20c. LOCATION — City or Town, State: Olney, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John B. Call MO0827		22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Narcotic Intoxication	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending Investigation 8 [ ] Could not be determined	28c. DATE OF INJURY (Month, Day, Year): found 3/21/92 Ukn M	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED: Unknown
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): found at home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 11415 Commonwealth Dr., apt. T-1 Rockville, Md.

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ 03/21/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] D. KOROS 111 PENN STREET, BALTIMORE, MARYLAND 21201		
31. DATE FILED (Month, Day, Year): MAR 24 '92	32. REGISTRAR'S SIGNATURE: [signature] Davidson-Randall	

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DHMH-16 Rev 1/89

92 09470

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Donald Leamond Bruner

2. DATE OF DEATH (Month, Day, Year): 3-21-92

3. TIME OF DEATH: 1 00 A M

4. SOCIAL SECURITY NUMBER: 579-46-7767

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 57 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Sept. 12, 1934

8. BIRTHPLACE (State or Foreign Country): Washington, DC

9a. FACILITY NAME (If not institution, give street and number): 3908 Jeffry Street

9b. CITY, TOWN OR LOCATION OF DEATH: Wheaton

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Wheaton

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 3908 Jeffry Street

10f. ZIP CODE: 20906

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 4

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Architect

16b. KIND OF BUSINESS/INDUSTRY: Architectual

17. FATHER'S NAME (First, Middle, Last): Luther Randolph Bruner, Sr.

18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Green

19a. INFORMANT'S NAME (Type/Print): Marlene Weaver Bruner

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3908 Jeffry Street, Wheaton, Maryland 20906

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lincoln Memorial Cemetery — DATE: 3/24/92

20c. LOCATION — City or Town, State: Suitland, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ronny Farrah M00198

22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiovascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b.	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Lauber MD

29c. LICENSE NUMBER: D08546

29d. DATE SIGNED (Month, Day, Year): ▶ 3-21-91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Lauber MD 8218 Wisconsin Ave Bethesda

31. DATE FILED (Month, Day, Year): MAR 23 '92

32. REGISTRAR'S SIGNATURE: Lia Davidson Randall

DHMH-16 Rev 1/89

92 09471

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): Gerald Francis Boesen			2. DATE OF DEATH (Month / Day / Year): 3 / 19 / 92	3. TIME OF DEATH: 3:00 A M
4. SOCIAL SECURITY NUMBER: 349-26-8421	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-30-1935	8. BIRTHPLACE (State or Foreign Country): Illinois
9a. FACILITY NAME (If not institution, give street and number): 80 West Deer Park Road, # 2		9b. CITY, TOWN OR LOCATION OF DEATH: Gaithersburg		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 80 West Deer Park Road		10f. ZIP CODE: 20877	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1955-1958	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yee, specify Cuben, Mexicen, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	16b. KIND OF BUSINESS/INDUSTRY: U.S. Postal Service	
17. FATHER'S NAME (First, Middle, Last): Clarence Boesen		18. MOTHER'S NAME (First, Middle, Maiden Surname): Loretto Carroll	
19a. INFORMANT'S NAME (Type/Print): Stella R. Boesen		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 80 West Deer Park Rd., Gaithersburg, MD. 20877	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery	DATE: 3-23	20c. LOCATION — City or Town, State: Cheltenham, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael D. Gilbury	22. NAME AND ADDRESS OF FACILITY: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Heart Failure	1 hr
	OUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. coronary artery disease	2 y
	OUE TO (OR AS A CONSEQUENCE OF):	
	c. myocardial infarction	10 y
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William B. Swann, DO	29c. LICENSE NUMBER: H37188	29d. DATE SIGNED (Month, Day, Year): ▶ March 20, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): William B. Swann, Jr., ~~M.D.~~ D.O., 19741 Executive Park Cir., Germantown, MD. 20874

31. DATE FILED (Month, Day, Year): MAR 23 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

92 09472

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 5 and 6 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frank C. Bogdan				2. DATE OF DEATH (Month, Day, Year): 3 14 92	3. TIME OF DEATH: 11:45 p M
4. SOCIAL SECURITY NUMBER: 091-05-6209	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9-02-1902	8. BIRTHPLACE (State or Foreign Country): NewJersey
9a. FACILITY NAME (If not institution, give street and number): 17908 Ednor View Terrace			9b. CITY, TOWN OR LOCATION OF DEATH: Ashton		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Ashton	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 17908 Ednor View Terrace		10f. ZIP CODE: 20861	10g. CITIZEN OF WHAT COUHTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDEHT EVER IH U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPAHIC ORIGIN? (Specify Yee or Ho— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1-12; College (1-4 or 5+): 5 +	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Attorney-Accountant	16b. KIND OF BUSINESS/INDUSTRY: Private- Self Employed	
17. FATHER'S HAME (First, Middle, Last): Andrew Bogdan		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Unknown	
19a. INFORMANT'S HAME (Type/Print): Rosemary Whalen		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17908 Ednor View Terr., Ashton, Md. 20861	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AHD DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Anthonys Church Cem.	DATE: 3-19-1992	20c. LOCATION — City or Town, State: Butler, New Jersey
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Clark & Wilson		22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. 20904	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetions that ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, ahock, or heert feilura. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory failure	minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated event resulting in death) LAST	b. Widespread metastatic disease	1 yr
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO	24b. WERE AUTOPSY FINDIHGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] HO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [✓] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] ND	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard P. Delaney MD	29c. LICENSE HUMBER: D02338	29d. DATE SIGNED (Month, Day, Year): ▶ 3/18/92
30. NAME AND ADDRESS OF PERSOH WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard P. Delaney, MD	2415 Musgrove Rd. Silver Spring , Md	
31. DATE FILED (Month, Day, Year): MAR 20 '92	32. REGISTRAR'S SIGNATURE: Barbara Davidson-Randall	

DHMH-16 Rev 1/89

92 09473

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Richard G. Buckingham			2. DATE OF DEATH (Month, Day, Year): March 14 1992	3. TIME OF DEATH: 12:50 P M
4. SOCIAL SECURITY NUMBER: 214-36-3194	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): December 3, 1914	8. BIRTHPLACE (State or Foreign Country): Washington,DC
9a. FACILITY NAME (If not institution, give street and number): 522 W. Montgomery Ave.		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 522 West Montgomery Ave.,		10f. ZIP CODE: 20850	10g. CITIZEN OF WHAT COUNTRY?: US

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5+	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Doctor of Veterinary Medicine	16b. KIND OF BUSINESS/INDUSTRY: Veterinarian	
17. FATHER'S NAME (First, Middle, Last): David E. Buckingham		18. MOTHER'S NAME (First, Middle, Maiden Surname): Roberta Randall	
19a. INFORMANT'S NAME (Type/Print): Richard G. Buckingham, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 4202 Rockville, Maryland 20850	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND OATE OF DISPOSITION (Name of cemetery, crematory or other place): Rockville Cemetery	DATE: 3-18	20c. LOCATION — City or Town, State: Rockville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ David E. Perry M00803		22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. COPD	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Bladder Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Cachexia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Urinal Retention	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression, Bronchitis Defecation

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Douglas R Shumaker MD	29c. LICENSE NUMBER: D27301	29d. DATE SIGNED (Month, Day, Year): ▶ 3/16/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DOUGLAS R. SHUMAKER MD 615 W. MONTGOMERY AVE, ROCKVILLE MD 20850

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31. DATE FILED (Month, Day, Year): MAR 19 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09474
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOUGLAS RAY BARROWMAN

2. DATE OF DEATH (Month, Day, Year): MARCH 16, 1992

3. TIME OF DEATH: 6:30 P.M

4. SOCIAL SECURITY NUMBER: 231-44-1301

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 53 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): FEB. 23, 1939

8. BIRTHPLACE (State or Foreign Country): VIRGINIA

9a. FACILITY NAME (If not institution, give street and number): 11802 HENRY FLEET DRIVE

9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE

9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: MONTGOMERY

10c. CITY, TOWN OR LOCATION: ROCKVILLE

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO

10e. STREET AND NUMBER: 11802 HENRY FLEET DRIVE

10f. ZIP CODE: 20854

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 4

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BRANCH CHIEF

16b. KIND OF BUSINESS/INDUSTRY: GOVERNMENT

17. FATHER'S NAME (First, Middle, Last): CHARLES BARROWMAN

18. MOTHER'S NAME (First, Middle, Maiden Surname): RUBY ROSE

19a. INFORMANT'S NAME (Type/Print): DONNA J. BARROWMAN

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11802 HENRY FLEET DRIVE, ROCKVILLE, MD 20854

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY — DATE: 3/19

20c. LOCATION — City or Town, State: SILVER SPRING, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]

22. NAME AND ADDRESS OF FACILITY: 500 UNIVERSITY BLVD., W., SIL.SP., MD 20901
FRANCIS J. COLLINS FUNERAL HOME, INC.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseasee, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart feilure. List only one ceuse on eech line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Adenocarcinoma
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in deeth) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death: years

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D 15046

29d. DATE SIGNED (Month, Day, Year): 3/18/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEPHEN J. NEWMAN, M.D. 11500 OLD GEROGETOWN ROAD, ROCKVILLE, MD 20852

31. DATE FILED (Month, Day, Year): MAR 19 1992

32. REGISTRAR'S SIGNATURE: [signature]

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY NELSON BEARD — Mary N. Beard
2. DATE OF DEATH (Month, Day, Year): 3 - 17 - 92
3. TIME OF DEATH: 2232 M
4. SOCIAL SECURITY NUMBER: 578-26-6662
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): OCT. 7, 1908
8. BIRTHPLACE (State or Foreign Country): CONNECTICUT
9a. FACILITY NAME (If not institution, give street and number): Leland Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale
9c. COUNTY OF DEATH: P.G.

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: MONTGOMERY
10c. CITY, TOWN OR LOCATION: ROCKVILLE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 199 ROLLINS AVENUE
10f. ZIP CODE: 20852
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): CARL O. NELSON
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE F. STENSON
19a. INFORMANT'S NAME (Type/Print): ROBERT J. BEARD, JR. (SON)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4915 BRENTLEY ROAD, TEMPLE HILLS, MD 20748
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY — DATE: 3/18
20c. LOCATION — City or Town, State: ALEXANDRIA, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stan D Blue
22. NAME AND ADDRESS OF FACILITY: 500 UNIVERSITY BLVD., W., SIL.SP., MD 20901 — FRANCIS J. COLLINS FUNERAL HOME, INC.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Atherosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypotension
Acute Renal Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Edward M. Dowd MD
29c. LICENSE NUMBER: D1131
29d. DATE SIGNED (Month, Day, Year): ▶ 3/18/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LELAND MEMORIAL HOSPITAL, 4409 EAST-WEST HIGHWAY, RIVERDALE, MD 20738
31. DATE FILED (Month, Day, Year): MAR 19 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Block			2. DATE OF DEATH (Month, Day, Year): March 17 1992	3. TIME OF DEATH: 12:30pm M
4. SOCIAL SECURITY NUMBER: 082 12 1959	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 27, 1921	8. BIRTHPLACE (State or Foreign Country): Czechoslovakia
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1010 Playford Lane		10f. ZIP CODE: 20901	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Brailist	16b. KIND OF BUSINESS/INDUSTRY: Prince Georges County Board of Education	
17. FATHER'S NAME (First, Middle, Last): Harry Klein		18. MOTHER'S NAME (First, Middle, Maiden Surname): Serena Schwimmer	
19a. INFORMANT'S NAME (Type/Print): Herbert Block		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10 above	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Lebanon Cem. 3/18/92	20c. LOCATION — City or Town, State: Adelphi, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Ives-Pearson Funeral Homes Falls Church, VA 22046	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	SEPSIS	3 Days
DUE TO (OR AS A CONSEQUENCE OF):	ACUTE LEUKEMIA.	2 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):		
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE.
Hepatic Failure
PNEUMONIA.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D20885	29d. DATE SIGNED (Month, Day, Year): ▶ March 17 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Penny L. Bisk 10313 Georgia Avenue #209 Silver Spring, MD 20902		
31. DATE FILED (Month, Day, Year): MAR 19 '92	32. REGISTRAR'S SIGNATURE: [signature]	

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): P. GAIL D. BEREZOSKI (Gail D. Berezoski)			2. DATE OF DEATH (Month, Day, Year): 3-17-92	3. TIME OF DEATH: 9 4 A M
4. SOCIAL SECURITY NUMBER: 215-52-9923	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 45 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): FEB. 2, 1947	8. BIRTHPLACE (State or Foreign Country): WASHINGTON, DC
9a. FACILITY NAME (If not institution, give street and number): SUBURBAN HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: GAITHERSBURG	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 431 CHRISTOPHER AVENUE, #T-4		10f. ZIP CODE: 20879	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): I	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): EXECTIVE SECRETARY	16b. KIND OF BUSINESS/INDUSTRY: INSURANCE

17. FATHER'S NAME (First, Middle, Last): JOHN P. Dunnigan	18. MOTHER'S NAME (First, Middle, Maiden Surname): GERTRUDE LINCOLN
19a. INFORMANT'S NAME (Type/Print): JOHN P. Dunnigan , JR.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3890 MARYLAND MANOR DIRVE, MONROVIA, MD 21770

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): PARKLAWN CEMETERY	DATE: 3/20/	20c. LOCATION — City or Town, State: ROCKVILLE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Carcinoma of the Cervix, DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. metastatic DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Tauber MD	29c. LICENSE NUMBER: D08546	29d. DATE SIGNED (Month, Day, Year): ▶ 3-17-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Tauber 8218 Wisconsin Ave Bethesda md.

31. DATE FILED (Month, Day, Year): MAR 20 '92	32. REGISTRAR'S SIGNATURE: [signature]

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BLAINE CARACTER					2. DATE OF DEATH (Month, Day, Year): 3 16 92	3. TIME OF DEATH: 2:15 P M
4. SOCIAL SECURITY NUMBER: 211-28-8434	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 55 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb 10, 1937	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE HOSPITAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY MD		9c. COUNTY OF DEATH: PG	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGE	10c. CITY, TOWN OR LOCATION: CAPITAL HTS	10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 4906 DEANWOOD DR		10f. ZIP CODE: 20743	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XX YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 2-7-42- 7-7-57	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plasterer	16b. KIND OF BUSINESS/INDUSTRY: PVT	
17. FATHER'S NAME (First, Middle, Last): JAMES CARACTER		18. MOTHER'S NAME (First, Middle, Maiden Surname): GRACE JOHNSON	
19a. INFORMANT'S NAME (Type/Print): JANICE CARACTER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4906 DEANWOOD DR, CAPITAL HTS, MD 20743	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): HARMONY MEM CEMETERY	DATE: 3-21-92	20c. LOCATION — City or Town, State: LANDOVER MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY: J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD, LANDOVER MD 20785	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ss cerdiec or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Cardiopulmonary arrest	
DUE TO (OR AS A CONSEQUENCE OF):	b. Intracerebral bleed.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	c.	
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: 1st year resident. FOR DR. TURKOWITZ (THE ATTENDING)	29c. LICENSE NUMBER: 24215	29d. DATE SIGNED (Month, Day, Year): ▶ 3-18-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHITRA VENKATRAMAN MD PGHC CHEVERLY MD (FOR THE ATTENDING DR. TURKOWITZ)			
31. DATE FILED (Month, Day, Year): MAR 19 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH-18 Rev 1/89

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92 09479

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jeremiah Francis Chapman JR.
2. DATE OF DEATH (Month, Day, Year): 3-15-92
3. TIME OF DEATH: 1:30 P M
4. SOCIAL SECURITY NUMBER: 219-36-7513
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 51 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): July 7 1940
8. BIRTHPLACE (State or Foreign Country): WASH D.C.
9a. FACILITY NAME (If not institution, give street and number): 1200 ELSA AVE
9b. CITY, TOWN OR LOCATION OF DEATH: LANDOVER
9c. COUNTY OF DEATH: PRINCE GEORGE

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: PRINCE GEORGE'S
10c. CITY, TOWN OR LOCATION: LANDOVER
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1200 ELSA AVE
10f. ZIP CODE: 20785
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CARPENTER HELPER
16b. KIND OF BUSINESS/INDUSTRY: PVT
17. FATHER'S NAME (First, Middle, Last): JEREMIAH FRANCIS CHAPMAN SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): MYRTLE JACKSON
19a. INFORMANT'S NAME (Type/Print): MYRTLE CHAPMAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1200 ELSA AVE, LANDOVER MD 20785
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HARMONY MEM CEMETERY — DATE: 3-21-92
20c. LOCATION — City or Town, State: LANDOVER MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jimmy C. Neal Sr.
22. NAME AND ADDRESS OF FACILITY: J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD, LANDOVER MD 20785

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD
29c. LICENSE NUMBER: D21230
29d. DATE SIGNED (Month, Day, Year): 3-15-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P Rodriguez MD, 5709 Baymeadow Dr. Glen Burnie, MD 21061

31. DATE FILED (Month, Day, Year): MAR 19 1992
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

(3)

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 09480

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mildred B. COTTMAN			2. DATE OF DEATH (Month, Day, Year): March 13, 1992	3. TIME OF DEATH: 0237 M
4. SOCIAL SECURITY NUMBER: 214-34-5876	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 54 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 6-7-1937	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY		9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Wicomico	10c. CITY, TOWN OR LOCATION: Wetipquin	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 1, Box 115A Lankford Rd.		10f. ZIP CODE: 21856	10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic	16b. KIND OF BUSINESS/INDUSTRY: None	
17. FATHER'S NAME (First, Middle, Last): Raymond Burrell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebea Lankford	
19a. INFORMANT'S NAME (Type/Print): Tonia Cottman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt.1 Box 115A Lankford Rd. Wetipquin	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Odd Fellows Cemetery	DATE:	20c. LOCATION — City or Town, State: Wetipquin, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys B. Stewart		22. NAME AND ADDRESS OF FACILITY: 821 West Rd. Clinton F Stewart-Salis. Md. 21801	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute myocardial infarction	Hours
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary artery disease	Years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Atrial + ventricular dysrhythmias	Years
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Steph Pavlos MD	29c. LICENSE NUMBER: D 41721	29d. DATE SIGNED (Month, Day, Year) ▶ 3/13/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEPHAN PAVLOS MD SALISBURY MD 21801

31. DATE FILED (Month, Day, Year): MAR 16 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

5

DHMH-16 Rev 1/89

92 09481

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RITA Chavis
2. DATE OF DEATH (Month, Day, Year): 3 22 92
3. TIME OF DEATH: 1700 M
4. SOCIAL SECURITY NUMBER: 578-46-3724
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 59 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5/19/1932
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Wash. Adv. Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park
9c. COUNTY OF DEATH: P.G.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: P.G.
10c. CITY, TOWN OR LOCATION: Capital Heights
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 505 Suffolk Ave Apt 421
10f. ZIP CODE: 20743
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic
16b. KIND OF BUSINESS/INDUSTRY: Homemaker
17. FATHER'S NAME (First, Middle, Last): William A. Thompson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Proctor
19a. INFORMANT'S NAME (Type/Print): Kathy A. Chavis
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6547 Hilmar Dr. #404 Forestville MD 20747
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cem — DATE: 3/27/92
20c. LOCATION — City or Town, State: Clinton MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lloyd Cater
22. NAME AND ADDRESS OF FACILITY: Adams Funeral Home P.A. Aquasco MD 20608

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory failure	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Metastatic lung cancer	1½ years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D33482
29d. DATE SIGNED (Month, Day, Year): ▶ 3/23/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sajeev Anand, MD 7227-B Hanover Pkwy, Greenbelt, MD 20770
31. DATE FILED (Month, Day, Year): MAR 25 '92
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09482

EL 1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lena C. Campbell		2. DATE OF DEATH (Month, Day, Year): 3 21 92	3. TIME OF DEATH: 845 PM
4. SOCIAL SECURITY NUMBER: 577-07-3330	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Apr. 23, 1913
8. BIRTHPLACE (State or Foreign Country): Virginia			
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Rockville	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3928 Wendy Lane	10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1-11th; College (1-4 or 5+): --	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Hairstylist	16b. KIND OF BUSINESS/INDUSTRY: Kanns, Inc.,	
17. FATHER'S NAME (First, Middle, Last): Louis Caron	18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Kewley		
19a. INFORMANT'S NAME (Type/Print): Emily Annis	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3928 Wendy Lane, Silver Spring, Md. 20906		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery	20c. LOCATION — City or Town, State: Brentwood, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Clark E Wise	22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. 20904		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Emphysema	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Congestive heart failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Coronary heart disease	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Organic brain syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: K. Sudhakar, M.D	29c. LICENSE NUMBER: D35792	29d. DATE SIGNED (Month, Day, Year): ▶ 3-22-92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. SUDHAKAR 50 W. EDMONSTON DR. #304 ROCKVILLE, MD 20852

31. DATE FILED (Month, Day, Year): MAR 24 '92	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

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92 09483

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie George Chaconas
2. DATE OF DEATH (Month, Day, Year): March 18, 1992
3. TIME OF DEATH: 2:20 P M
4. SOCIAL SECURITY NUMBER: 578-52-9925
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 92 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Jan. 15, 1900
8. BIRTHPLACE (State or Foreign Country): Greece
9a. FACILITY NAME (If not institution, give street and number): 4701 Willard Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Chevy Chase
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Chevy Chase
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4701 Willard Avenue
10f. ZIP CODE: 20815
10g. CITIZEN OF WHAT COUNTRY?
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): John Stathopoulos
18. MOTHER'S NAME (First, Middle, Maiden Surname): Emily Garbis
19a. INFORMANT'S NAME (Type/Print): Stella Stevens
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4701 Willard Ave., Chevy Chase, MD 20815
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery — DATE: 3/20
20c. LOCATION — City or Town, State: Brentwood, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael E. Nelson
22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, DC 20016

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Alzheimer's Disease — 8/91
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Gastric outlet obstruction; Congestive heart failure; Left renal mass.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Nicholas L. Christopher, M.D.
29c. LICENSE NUMBER: DC. 1583
29d. DATE SIGNED (Month, Day, Year): ▶ March 18, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Nicholas L. Christopher, M.D., 3301 New Mexico Ave, NW, Washington, D.C. 20016

31. DATE FILED (Month, Day, Year): MAR 20 '92
32. REGISTRAR'S SIGNATURE: Lidia Davidson-Kindell

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LILLIAN C. CONSTABLE			2. DATE OF DEATH (Month, Day, Year): MARCH 13 1992	3. TIME OF DEATH: 5:00 PM
4. SOCIAL SECURITY NUMBER: 577-01-3091	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 94 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): MARCH 4, 1898	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): BETHESDA RETIREMENT & NURSING CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVY CHASE		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGE	10c. CITY, TOWN OR LOCATION: TAKOMA PARK		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 7109 13TH AVENUE		10f. ZIP CODE: 20912		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK OFFICE	16b. KIND OF BUSINESS/INDUSTRY: C & P TELEPHONE		
17. FATHER'S NAME (First, Middle, Last): RICHARD L. COUNTS, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): EDITH MEADE		
19a. INFORMANT'S NAME (Type/Print): ARTHUR H. COUNTS (BROTHER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7109 13TH AVENUE TAKOMA PARK, MARYLAND 20912		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY	DATE: 3/17	20c. LOCATION — City or Town, State: SUITLAND, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD 20901			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertension @ cerebro vascular disease	10 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cerebral infarction DUE TO (OR AS A CONSEQUENCE OF):	4 weeks
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robert V. Choisser MD	D 13777	▶ MAR. 13, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT V. CHOISSER, M.D. 5530 WISCONSIN AVENUE CHEVY CHASE, MARYLAND 20815

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 19 1992	Julia Davidson-Nordell

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DHMH-16 Rev 1/89

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1 · FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary E. Crump			2. DATE OF DEATH (Month, Day, Year): 3/17/92	3. TIME OF DEATH: 3:22 A. M
4. SOCIAL SECURITY NUMBER: 202-22-1921	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7/30/1909	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel/Beltsville Hosp		9b. CITY, TOWN OR LOCATION OF DEATH: Laurel	9c. COUNTY OF DEATH: Prince George's	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Beltsville	10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6128 Odell Road		10f. ZIP CODE: 20705	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housekeeper	16b. KIND OF BUSINESS/INDUSTRY: University of MD	
17. FATHER'S NAME (First, Middle, Last): John H. Crump, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lottie Ross	
19a. INFORMANT'S NAME (Type/Print): Maria V. Matthews (sister)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6128 Odell Rd., Beltsville, MD 20705		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Md. Nat'l Mem. Park DATE: 3/20	20c. LOCATION — City or Town, State: Laurel, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George R. Snowden	22. NAME AND ADDRESS OF FACILITY: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart failure	1 hr.
DUE TO (OR AS A CONSEQUENCE OF): b.	Arteriosclerotic Cardiovascular Disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Hypertensive Vascular Disease	years
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D15666	29d. DATE SIGNED (Month, Day, Year): ▶ 3/17/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Denis A. Schuman MD 14701 Laurel Park Drive #102 Laurel MD 20707

31. DATE FILED (Month, Day, Year): MAR 19 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Snowden

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 09486

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rowena Hedgepeth DAVID				2. DATE OF DEATH (Month, Day, Year): March 11 1992	3. TIME OF DEATH: 09 44 AM M
4. SOCIAL SECURITY NUMBER: 578-40-0404	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 25, 1928	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): DOCTORS COMMUNITY HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: LANHAM		9c. COUNTY OF DEATH: PRINCE GEORGE

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Lanham	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9010 Varnum Street		10f. ZIP CODE: 20706	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Willie C. Hedgepeth		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Mills	
19a. INFORMANT'S NAME (Type/Print): Alvis C. David		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3201 Dalewood Road, Fort Washington, Maryland 20744	

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MD VETS CEMETERY	DATE: March 16, 1992	20c. LOCATION — City or Town, State: Cheltenham, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard Rendon		22. NAME AND ADDRESS OF FACILITY: Rendon-Hale Lanham Funeral Home, 9013 Annapolis Road, Lanham, Maryland 20706	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiogenic shock	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Severe tachycardia	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	acute myocardial infarction	
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Coronary Ischemia	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: anoxic encephalopathy Metabolic acidosis, Seizure disorder

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
☒ 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: RT Rustagi MD	29c. LICENSE NUMBER: D24270	29d. DATE SIGNED (Month, Day, Year) ▶ 3/11/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. R. RUSTAGI, 6132 Landover Rd, Cheverly Md 20785		
31. DATE FILED (Month, Day, Year): MAR 16 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
TEFFY	GERALD	DENT	03 10 1992	11:15 P.M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
251-11-2450	1 [X] M 2 [ ] F	34 YRS.			March 12, 1957	South Carolina

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
PRINCE GEORGES HOSPITAL	CHEVERLY	PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince George's	New Carrollton	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
8407 Carrollton Parkway	20784	United States

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO	1 [ ] YES 2 [X] NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12th Grade		Rodman	WSSC

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Julius Dent	Martha

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Regina B. Dent	8407 Carrollton Parkway, New Carrollton, MD.

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Maryland Veterans Cemetery	3/17	Cheltenham, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
John T. Stewart, III	Stewart Funeral Home 4001 Benning Rd., N.E. Wash.D.C.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MULTIPLE INJURIES	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	03-10-1992	5:25P.M	1 [ ] YES 2 [X] NO	DRIVER AUTO/AUTO IMPACT

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
ON STREET	RIVERDALE RD. RIVERDALE, P.G. CO. MD.

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Mario F. Golle Jr. M.D.	O.C.M.E.	03-12-1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
MARIO F. GOLLE JR. M.D.	111 PENN STREET BALTIMORE MARYLAND 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 16 1992	Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT MARSHALL DOLBY				2. DATE OF DEATH (Month, Day, Year): March 18, 1992	3. TIME OF DEATH: 6:39 a M
4. SOCIAL SECURITY NUMBER: 578-18-4215	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov. 22, 1924	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): Doctors Community Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Lanham		9c. COUNTY OF DEATH: Prince George's	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Lanham	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 7613 Kidmore Lane		10f. ZIP CODE: 20706	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Park & Planning Commission	16b. KIND OF BUSINESS/INDUSTRY: Maryland National Park
17. FATHER'S NAME (First, Middle, Last): Bird Dolby		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lelia D. Burrows	
19a. INFORMANT'S NAME (Type/Print): Milena Dolby (Spouse)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7613 Kidmore Lane, Lanham, Maryland 20706	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland State Veterans Cem. DATE: 03/23/92	20c. LOCATION — City or Town, State: Cheltenham, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark A Rohm		22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute myocardial Infarct.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Coronary Artery Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D08520	29d. DATE SIGNED (Month, Day, Year): ▶ 3/18/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Tomas J. Hernandez M.D., 3001 Hospital Dr., Cheverly, Md. 20785

31. DATE FILED (Month, Day, Year): MAR 20 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-t6 Rev t/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page ... be filled by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ... be detached for use as the burial-transit permit. Pages 1, 2, 3 should
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DORIS L DOGAN					2. DATE OF DEATH (Month, Day, Year): 3 13 92		3. TIME OF DEATH: 10:45 P M
4. SOCIAL SECURITY NUMBER: 246 90 7913	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 40 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 05-18-1951		8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): 18361 HALLMARK COURT					9b. CITY, TOWN OR LOCATION OF DEATH: GAITHERSBURG		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT							
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY				10c. CITY, TOWN OR LOCATION: GAITHERSBURG		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 18361 HALLMARK COURT					10f. ZIP CODE: 20879		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 2 years College (1-4 or 5+)					16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Insurance Claim Adjuster		16b. KIND OF BUSINESS/INDUSTRY: Private
17. FATHER'S NAME (First, Middle, Last): WILLIAM R. HEDGEPETH					18. MOTHER'S NAME (First, Middle, Maiden Surname): DOROTHY ARRINGTON		
19a. INFORMANT'S NAME (Type/Print): MIA DOGAN (DAUGHTER)					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18361 HALLMARK COURT; GAITHERSBURG, MARYLAND 20879		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): CHURCH CEMETERY DATE: 3-19-92		20c. LOCATION — City or Town, State: BATTLEBORO, N.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶					22. NAME AND ADDRESS OF FACILITY: JOHNSON & JENKINS FUNERAL HOME, INC. 716 KENNEDY STREET, N.W.; WDC 20011		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. BREAST CANCER DUE TO (OR AS A CONSEQUENCE OF):	5 YRS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Peter B. Sherer MD	D-21910	▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter B. Sherer MD 3947 Fessard Dr. Wheaton, md 20910

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 19 1992	Julia Davidson-Randall

OHMH-16 Rev 1/69

11

MAGDOLENA DORMUTH

92 09490

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MAGDALENA DORMUTH			2. DATE OF DEATH (Month / Day / Year): 3 / 14 / 92	3. TIME OF DEATH: 3:15 AM
4. SOCIAL SECURITY NUMBER: 261-65-0480	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)	7. DATE OF BIRTH (Month, Day, Year): 7-22-04	8. BIRTHPLACE (State or Foreign Country): ROMANIA
9a. FACILITY NAME (If not institution, give street and number): SALISBURY NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY		9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: WICOMICO	10c. CITY, TOWN OR LOCATION: SALISBURY	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: RT 17 Box 287 Twilly Bridge Road		10f. ZIP CODE: 21801	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 Years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Domestic	
17. FATHER'S NAME (First, Middle, Last): JOHN DECKER		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET SCHWEDTYE	
19a. INFORMANT'S NAME (Type/Print): ANNA MOHR		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT 17 BOX 286 SALISBURY, MD 21801	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): SPRINGHILL MEMORY GARDENS DATE: 3-16	20c. LOCATION — City or Town, State: SALISBURY, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John M. Holloway		22. NAME AND ADDRESS OF FACILITY: HOLLOWAY FUNERAL HOME 501 SNOW HILL RD SALISBURY, MD 21801	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Pulmonary Infection	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Dementia	
	c. DUE TO (OR AS A CONSEQUENCE OF): Cerebrovascular Accident	
	d. DUE TO (OR AS A CONSEQUENCE OF): Hypertension	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D39815	29d. DATE SIGNED (Month, Day, Year): 3/14/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM ROBINS M.D., 1104 HEALTHWAY DRIVE, SALISBURY, MD. 21801

31. DATE FILED (Month, Day, Year): MAR 17 1992	32. REGISTRAR'S SIGNATURE: Julia Landon-Marshall

DHMH 16 Rev 1/89

92 09491

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained by use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): Luella JONES Davis			2. OATE OF DEATH: MONTN 03 DAY 12 YEAR 92	3. TIME OF DEATH: 4:30 aM
4. SOCIAL SECURITY NUMBER: 219-07-6023	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-10-1921	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): BERLIN NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: BERLIN		9c. COUNTY OF DEATH: WORCESTER

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: WICOMICO	10c. CITY, TOWN OR LOCATION: WILLARDS	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: RT. 346, BOX 95		10f. ZIP COOE: 21874	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): EDWARD J. JONES		18. MOTHER'S NAME (First, Middle, Maiden Surname): VIRGIE WEBB	
19a. INFORMANT'S NAME (Type/Print): JOHN R. DAVIS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT. # 346,BOX 95, WILLARDS,MD. 21874	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DENNIS CEMETERY	20c. LOCATION — City or Town, State: WILLARDS,MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gerald C. Bounds		22. NAME AND ADDRESS OF FACILITY: BOUNDS FUNERAL HOME 705 EAST MAIN ST.,SALISBURY,MD.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. End Stage Renal Failure	1mo
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Glomerulo Sclerosis	2yr
	c. Arteriosclerosis	yr
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Failure CHF

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D02026	29d. OATE SIGNED (Month, Day, Year): ▶ 3-12-92

30. NAME ANO AOORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Federico G. Arthes, MD 1622A Ocean Pines, Berlin, MD 21811

31. DATE FILED (Month, Day, Year): MAR 13 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

12

DHMH-16 Rev 1/89

92 09492

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Thomas	Eugene	Drury	March 13, 1992	11:00 P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
579-18-7670	1 [X] M 2 [ ] F	78 YRS.			7-2-1913	Wash. DC

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Physicians Memorial Hospital	La Plata	Charles

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland		Hughesville	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Route 1 Box 256	20637	U.S.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12th		Cabinet Maker	'Saah Bookcase Shop

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Parry Lee Drury	Myrtle Lee Wood

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward McClung	Route 1, Box 256, Hughsville, MD 20637

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)	Georgetown Med. School	3-16-92	Washington DC

21. SIGNATURE OF FUNERAL SERVICE LICENSEE

22. NAME AND ADDRESS OF FACILITY: Austin Royster Funeral Home, 3605 14th Street, N.W. Wash. DC

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CONGESTIVE HEART FAILURE	2 Weeks
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	DILATED CARDIOMYOPATHY.	MANY YRS
DUE TO (OR AS A CONSEQUENCE OF):		
c.	COPD	MANY YRS
DUE TO (OR AS A CONSEQUENCE OF):		
d.	CHRONIC RENAL FAILURE	6 Months

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one) HOSPITAL:	OTHER:
1 [ ] YES 2 [X] NO	1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D 21173.	3/14/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NIRAV P. SHARMA MD 104 Pembrooke Square Waldorf, MD. 20601

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 19 1992	Gina Davidson-Randall

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DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 [illegible] retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09493
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERTA L. DOLPHIN

2. DATE OF DEATH (Month, Day, Year): 03 21 92

3. TIME OF DEATH: 4:15PM M

4. SOCIAL SECURITY NUMBER: 478-03-6574

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 76 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): May 16, 1915

8. BIRTHPLACE (State or Foreign Country): Iowa

9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER

9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY

9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: Virginia

10b. COUNTY: Fairfax

10c. CITY, TOWN OR LOCATION: Falls Church

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 6245 Wilson Blvd.

10f. ZIP CODE: 22044

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 3½

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrative Assistant

16b. KIND OF BUSINESS/INDUSTRY: Veteran's Administration

17. FATHER'S NAME (First, Middle, Last): Charles C. Livingstone

18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret French

19a. INFORMANT'S NAME (Type/Print): M. Jane Morgan

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6245 Wilson Blvd., Falls Church, VA 22044

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory — DATE: 3-22

20c. LOCATION — City or Town, State: Silver Spring, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ellen H. Rapp

22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Chronic Obstructive pulmonary disease	4 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Schizophrenia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Peter M Schuster MD

29c. LICENSE NUMBER: D22780

29d. DATE SIGNED (Month, Day, Year): ▶ 3 22 92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter M Schuster MD 7500 Greenway Ctr Dr Greenbelt Md 20770

31. DATE FILED (Month, Day, Year): MAR 24 92

32. REGISTRAR'S SIGNATURE: Julia Davidson Kendall

DNMH-16 Rev 1/89

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92 09494

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Anna Dartouzos		3 - 21 - 92	6-15 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
578-01-8874	1 ☐ M 2 ☒ F	86 YRS.			10-15-05	Greece

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Collingswood Nursing Center	Rockville	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Montgomery	Rockville	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
199 Rollins Ave.	20852	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
5		Waitress	Restaurant

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Michael Economopoulos	Katherine Economopoulos

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Milton G. Dartouzos	760 Clifftop Dr. Gaithersburg, MD 20878

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metropolitan Crematory	3/22	Alexandria, Virginia

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ J. E. [illegible] M00896	De Vol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. [illegible] Arteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF):	4 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Generalized Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF):	20 yrs.
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
[illegible] ; Dementia of multi-infarct type ; Hypothyroidism

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Henry C. Scruggs MD	D12504	▶ 3/21/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Henry C. Scruggs MD 5413 Cedar La Bethesda Md 20814

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAR 23 '92	Lydia Davidson Randall

DHMH-16 Rev 1/89

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92 09495

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JN. BAPTISTE ANDRE DESLANDES
ANDRE, DESLANDES

2. DATE OF DEATH (Month, Day, Year): 03 - 17 - 1992

3. TIME OF DEATH: 1213A M

4. SOCIAL SECURITY NUMBER: 069-50-4488

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 52 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): AUG. 25, 1939

8. BIRTHPLACE (State or Foreign Country): HAITI

9a. FACILITY NAME (If not institution, give street and number): SUBURBAN HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA

9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: PRINCE GEORGES

10c. CITY, TOWN OR LOCATION: HYATTSVILLE

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO

10e. STREET AND NUMBER: 8135 15th AVENUE, #3

10f. ZIP CODE: 20783

10g. CITIZEN OF WHAT COUNTRY?: HAITI

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 2

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CONSTRUCTION WORKER

16b. KIND OF BUSINESS/INDUSTRY: CONSTRUCTION

17. FATHER'S NAME (First, Middle, Last): MAX DESLANDES

18. MOTHER'S NAME (First, Middle, Maiden Surname): LUCIA FEQUIERE

19a. INFORMANT'S NAME (Type/Print): LAURA E. DESLANDES

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8135 15th AVENUE, #3, HYATTSVILLE, MD 20783

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GEORGE WASHINGTON CEMETERY
DATE: 3/21

20c. LOCATION — City or Town, State: ADELPHI, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Timothy M Campbell

22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC.
500 UNIVERSITY BLVD., W., SIL. SP., MD 20901

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Septic shock — 48 hours
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Unknown source
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Renal Failure, Anemia, Respiratory Failure, Gastrointestinal Bleeding, Diabetes mellitus, Coagulopathy

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James H Kruegshield, MD

29c. LICENSE NUMBER: D23091

29d. DATE SIGNED (Month, Day, Year): 19 Mar 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4915 Auburn Ave, Bethesda, Md 20814

31. DATE FILED (Month, Day, Year): MAR 20 '92

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

92 09496

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 - 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edward Joseph Doyle
2. DATE OF DEATH (Month, Day, Year): March 17, 1992
3. TIME OF DEATH: 10:50 PM M
4. SOCIAL SECURITY NUMBER: 045-10-6692
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 72 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): May 25, 1919
8. BIRTHPLACE (State or Foreign Country): Connecticut
9a. FACILITY NAME (If not institution, give street and number): 1726 Wilmart Street
9b. CITY, TOWN OR LOCATION OF DEATH: Rockville
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Rockville
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1726 Wilmart Street
10f. ZIP CODE: 20852
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Lawyer/CPA
16b. KIND OF BUSINESS/INDUSTRY: Private Practice
17. FATHER'S NAME (First, Middle, Last): Leo Doyle
18. MOTHER'S NAME (First, Middle, Maiden Surname): Charlotte Simpson
19a. INFORMANT'S NAME (Type/Print): J. Kevin Doyle
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3200 Tower Oaks Blvd., Rockville, Maryland 20852
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. John's Cemetery/Forest Glen — DATE: 3/21/92
20c. LOCATION — City or Town, State: Silver Spring, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert J. Farrah — M00198
22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Renal failure	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Congestive heart failure	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease
Chronic Obstructive Lung Disease
Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Lee R. Pennington, M.D.
29c. LICENSE NUMBER: D21115
29d. DATE SIGNED (Month, Day, Year): ▶ March 18, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lee R. Pennington, M.D. 5602 Shields Drive, Bethesda, Maryland 20817
31. DATE FILED (Month, Day, Year): MAR 19 '92
32. REGISTRAR'S SIGNATURE: Gina Lawler-Rudolph

DHMH-16 Rev 1/89

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92 09497

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VERA DOBROW			2. DATE OF DEATH (Month, Day, Year): 3 - 15 - 1992	3. TIME OF DEATH: 7:20 PM M
4. SOCIAL SECURITY NUMBER: 058-22-0583	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1 - 3 - 1922	8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGES	10c. CITY, TOWN OR LOCATION: LAUREL	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 12220 VALERIE LANE		10f. ZIP CODE: 20708	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): GEORGE GOLDENBERG		18. MOTHER'S NAME (First, Middle, Maiden Surname): BESSIE KAPLAN GOLDENBERG	
19a. INFORMANT'S NAME (Type/Print): EDGAR DOBROW		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12220 VALERIE LANE, LAUREL, MARYLAND 20708	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): JUDEAN MEMORIAL GARDEN; DATE:	20c. LOCATION — City or Town, State: OLNEY, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD. 20852	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet ceused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Respiratory Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneumonia, Aspiration	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lymphoma
Breast Carcinoma
Radiation Therapy

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: 024571	29d. DATE SIGNED (Month, Day, Year): ▶ 3/16/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jay Weiner MD 11501 Georgia Ave Wheaton, md 20902

31. DATE FILED (Month, Day, Year): MAR 18 '92	32. REGISTRAR'S SIGNATURE: [signature]

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DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 09498
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Martin Bernard Durkin				2. DATE OF DEATH (Month, Day, Year): March 16 1992	3. TIME OF DEATH: 8:10 A M
4. SOCIAL SECURITY NUMBER: 328-18-2474	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 7, 1922	8. BIRTHPLACE (State or Foreign Country): Illinois
9a. FACILITY NAME (If not institution, give street and number): 5903 Ipswich Road				9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda	9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 5903 Ipswich Road		10f. ZIP CODE: 20814	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Building Engineer	16b. KIND OF BUSINESS/INDUSTRY: A.F.L. C.I.O.
17. FATHER'S NAME (First, Middle, Last): Martin Patrick Durkin		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna MacNickolas	
19a. INFORMANT'S NAME (Type/Print): Mary Dorothy Durkin		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5903 Ipswich Road Bethesda, Maryland 20814	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery DATE: March 18, 1992	20c. LOCATION — City or Town, State: Silver Spring, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ George F. Reptart M00335		22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastic Gastric Cancer	6 months
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: 11506	29d. DATE SIGNED (Month, Day, Year): ▶ March 16, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frederick P. Smith, M.D. 5401 Western Avenue, NW, Washington, D.C. 20015

31. DATE FILED (Month, Day, Year): MAR 19 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Mandell

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): IRENE ELIZABETH EVERDALE (Irene E. Everdale)				2. DATE OF DEATH (Month, Day, Year): 3 16 92	3. TIME OF DEATH: 12:45 AM
4. SOCIAL SECURITY NUMBER: 577-01-7044	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 7, 1909	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Takoma Park	10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7051 Carroll Avenue		10f. ZIP CODE: 20912	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: ☒ 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: NO	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bank Teller	16b. KIND OF BUSINESS/INDUSTRY: Bank of Silver Spring	
17. FATHER'S NAME (First, Middle, Last): George W. Everdale		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Ida Schrumn	
19a. INFORMANT'S NAME (Type/Print): William E. Everdale		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2417 Griffen Street, Hyattsville, Maryland 20783	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Ft. Lincoln Cemetery, 03-19-92	DATE	20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 BALT. AVE., HYATTSVILLE, MD. 20781	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pancreatic Carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Valvular and Ischemic Heart Disease S/P Mitral Valve Replacement Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D25080	29d. DATE SIGNED (Month, Day, Year): ▶ 3/16/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frank N. Gravina, MD, 10313 Georgia Ave, Silver Spring, MD		
31. DATE FILED (Month, Day, Year): MAR 17 1992	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

(6)

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARRY EDMUNDS			2. DATE OF DEATH Month: 3 Day: 9 Year: 92	3. TIME OF DEATH: 12:25 AM
4. SOCIAL SECURITY NUMBER: 218-07-1911	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 80 YRS. (If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 7/31/11	8. BIRTHPLACE (State or Foreign Country): Wash., D.C.
9a. FACILITY NAME (If not institution, give street and number): So. MARYLAND HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON			9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Ft. Washington	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 3011 Merva Ct.	10f. ZIP CODE: 20744	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chef/Cook	16b. KIND OF BUSINESS/INDUSTRY: Railroad	
17. FATHER'S NAME (First, Middle, Last): Harry Edmunds	16. MOTHER'S NAME (First, Middle, Maiden Surname): Mamie Parham		
19a. INFORMANT'S NAME (Type/Print): Mary V. Edmunds	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as # 10 above		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Nat'l. Mem. Pk. DATE: 3/14/92	20c. LOCATION — City or Town, State: Laurel, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry N. Pratt	22. NAME AND ADDRESS OF FACILITY: H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hepatic failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Resp. failure
DUE TO (OR AS A CONSEQUENCE OF):
c. CA Prostate Metastasis
DUE TO (OR AS A CONSEQUENCE OF):
d. Spinal Cord Compression

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COPD
PUD

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: attnd	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 3/5/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ABULHASAN U ANSARI MD	8926 Woodyard Rd #101 Clinton MD 20735	
31. DATE FILED (Month, Day, Year): MAR 20 1992	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

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